THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)
Medicare Part B Specification for the
ANSI ASC X12 835 Implementation Guide
[Remittance]

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Introduction

The Health Care Financing Administration (HCFA) has adopted the American National Standards Institute (ANSI), Accredited Standards Committee (ASC) X12 Health Care Claim Payment/Advice (835) as the standard format for the electronic data interchange (EDI) of Medicare remittance advice data and the electronic transfer of payment for Medicare services. [For Part B providers, the 835 is offered in addition to the established electronic remittance option of the HCFA Part B National Standard Remittance Advice (NSF).]

A. Purpose of this Implementation Guide

This implementation guide is intended to provide assistance in the development and execution of the electronic transfer of remittance advice data and/or payment. All specifications in this document conform to ANSI ASC X12 835 standards, adopted for use by Medicare Part B. These specification are designed to be compatible with financial institutions' communications networks.

B. Scope and Applicability

The purpose of these standards is to expedite HCFA's goal of achieving a totally paperless claims processing and payment environment. The ANSI ASC X12 standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define a method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each carrier must provide these specific requirements separately.

This document does not address the specific requirements of non-Medicare payers. If providers choose to utilize 835 to exchange remittance data or electronic funds transfer (EFT) with other payors, they must contact the payors directly for their requirements.

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BACKGROUND

A. Electronic Data Interchange (EDI)

EDI is the acronym for Electronic Data Interchange. EDI is the exchange of information on routine business transactions in a standardized computer format; for example, data interchange between a Medicare carrier and a provider. EDI originated when a number of industries desired to save costs and reduce waste through the electronic transmission of business information. They were convinced that in this computerized world, standardization of formatted information was the most effective means of communicating with multiple trading partners.

EDI offers several advantages. In addition to standardized formats that can be used with multiple trading partners, technology now allows anyone with a computer and a modem to participate in EDI. With EDI, there is a substantial reduction in handling and processing time, and the risk of lost paper documents is eliminated.

As with any new technology, there are costs associated with EDI. These costs are likely to be similar to those incurred in any decision to automate.

B. ANSI and ASC X12

The American National Standards Institute (ANSI) coordinates voluntary standards in the United States. Many standards developers and participants support ANSI as the central body responsible for the identification of a single consistent set of voluntary standards called American National Standards. ANSI provides an open forum for all concerned interests to identify specific business needs, plan to meet those needs, and agree on standards. ANSI itself does not develop standards. ANSI approval of standards indicates that the principles of openness and due process have been followed in the approval procedures and that a consensus of those materially affected by the standards has been achieved.

In 1979, ANSI chartered a new committee, known as Accredited Standards Committee (ASC) X12, Electronic Data Interchange, to develop uniform standards for electronic interchange of business transactions. The work of ASC X12 is conducted primarily by a series of subcommittees and task groups whose major function is the development of new, and the maintenance of existing, EDI standards.

Currently, ASC X12 has more than 600 voluntary members. Membership is open to virtually all organizations and individuals with a material interest in the standards. Benefits include an opportunity to vote on every issue before the X12 committee and frequent information updates on committee activities and standards. The insurance subcommittee of ASC X12 includes representatives from health care payers, providers, provider associations, banks, software vendors and government agencies (Medicare, Medicaid, etc.).

C. HCFA Use of X12 Standards

In the near future, X12 standards are anticipated to be the national norm for electronic transmission of health care data. As part of HCFA's continuing commitment to achieve administrative savings through the use of electronic claim processing options, including the decision to migrate to financial EDI, HCFA has become a member of the X12 committee. HCFA's active participation in X12 is expected to accelerate the acceptance of specific electronic standards throughout the health care industry.

A version of the ANSI Health Care Claim Payment/ Remittance Advice (835) has been offered by FIs since October 1992. An 835 for carriers, as well as a Health Care Claim (837) for both FIs and carriers were implemented on October 1, 1993. The 835 for carriers has been designed to correspond to the NSF remittance. HCFA eliminated the use of local Medicare formats effective July 1, 1996.

D. Implementation Guide Changes

As an aid to the initial implementation for carriers, Appendix B provides a map of the NSF (Version 002.01) fields to the corresponding element locations on the 835. However, due to factors like the nature of balancing on the 835 and the differences between variable and fixed-length records, the map cannot provide one-to-one correspondence. Nonetheless, this implementation of the 835 should not require any additional reference to the NSF remittance for providers who choose only to receive the 835.

This implementation is specific to the Medicare Part B program, and has been developed within the standard for the ANSI ASC X12 835 transaction, version 003051. All future changes to this implementation guide will remain within the requirements of the X12 835 standard.

Implementation guide updates for version 003051will continue to be released through HCFA. ASC X12 subcommittees and task groups continue to develop and maintain EDI standards. To meet legislative and regulatory requirements, HCFA will participate with X12 to revise the standards. Revisions of HCFA ANSI ASC X12 implementation guides are anticipated to be released on an annual basis only if necessary.

HCFA may also need to revise the way Medicare Part B uses existing standards. Carriers will distribute copies of the revised implementation guide within three weeks to requesting providers or will make copies available electronically.

E. Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator of the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator.

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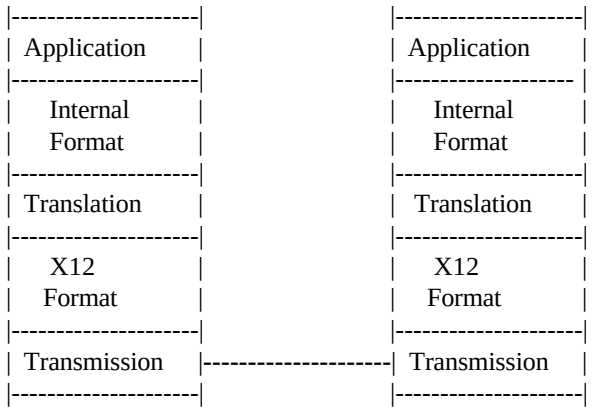
Important EDI Concepts

The insurance subcommittee health care task group (X12N-TG2) has developed, under the guidelines of ANSI ASC X12, several standards for the interchange of health care information between providers, payers and trading partners. EDI standards facilitate the exchange of information between different computers by providing a standard communication mechanism applicable to any computer system, and by conveying the information required for the processing of claims, payments, enrollments, eligibility, and other common business functions in health care.

These EDI standards have been designed for efficiency in electronic data interchange. They have not been designed as a standard way to solve the business needs of processing the data for adjudication or internal account balancing. Such functions are intrinsic to the trading partners that exchange the information, and therefore beyond the scope of the standards.

When a computer application communicates data to a different computer, the data must first be generated in an internal format, and then sent to the receiving computer in a standard format that both computers will understand. Finally, the receiving computer must convert the received data into an internal format for application processing.

Using common layer diagrams, this process would be represented as:



Before the advent of industry standards, the common format was unique to each pair of computer applications. With the introduction of X12 standards, the same format is used between multiple trading partners. Further, the process of "translating" internal data format to and from the X12 EDI format can be done by general purpose "translation software". The X12 EDI formatted data could be invisible to the applications, but visible to the translation software. The applications would only see their internal data format.

The translator software could be written in-house or purchased commercially. Most commercial translators are table-driven and they can be used to convert to and from numerous types of data or "transactions" with multiple business applications. Once a translator is installed, the same software can translate data between X12 formats and selected internal flat file formats, in either direction; for instance, to translate outgoing health insurance claims as well as incoming remittance advices.

With the recent explosion of EDI applications, the vendors of translation software have produced a wide variety of offerings, ranging from inexpensive PC-based packages to sophisticated mainframe-based translators that handle mailboxing, queues, and multiple versions of the standards simultaneously. Another important point is the degree to which the translator can be changed and updated with ease and flexibility whenever there is a new release of the standard.

One alternative to translators is to let a Value Added Network (VAN) or Clearinghouse do the translation. This option is generally more cost effective for smaller volume sites, or in cases where the initial investment in the required translation software may not be advisable.

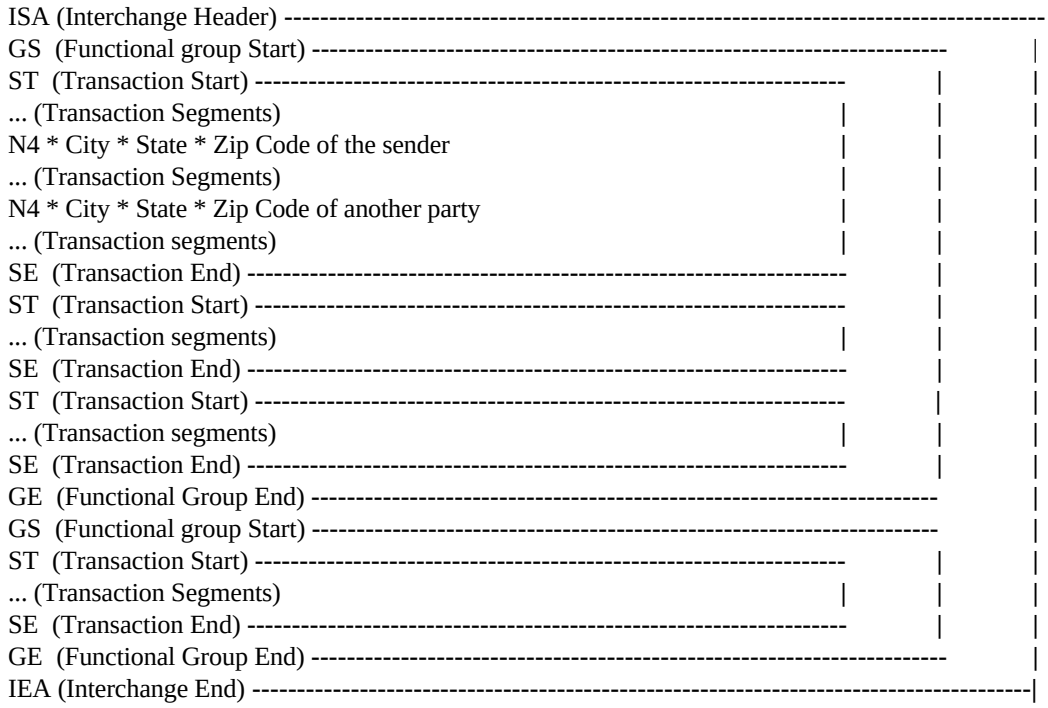
A. Interchange Overview

The transmission of data proceeds according to very strict format rules in order to insure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a "transaction". For instance, a group of health insurance claims sent from one provider to a Medicare Carrier or a remittance advice returned by that Carrier could each be considered a transaction.

Each transaction contains groups of logically related data in units called"segments". For instance, the "N4" segment used in the 835 conveys the city, state, zip code, and other geographic information. A transaction contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. Using an analogy, the transaction would be like a freight train, the segments would be the train's cars, and each segment could contain several data "elements" the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12N standard, as well as the sequence of segments in the transaction. In a more conventional computing environment, the segments would be similar to “records", and the elements equivalent to "fields".

Similar transactions, called "functional groups", are sent together within a transmission. Each functional group is prefaced by a "group start" segment and terminated by a "group end" segment. One or more functional groups are prefaced by an "interchange header", and followed by an "interchange trailer". This is illustrated below:



The interchange header and trailer segments envelope one or more functional groups or interchange-related control segments and perform the following functions:

Define the data element separators and the data segment terminators,
Identify the sender and receiver,
Provide control information for the interchange, and
Allow for authorization and security information.

B. Interchange Control Structure
Definitions and Concepts

Basic Structure

A data element corresponds to a data field in data processing terminology. It is the smallest named item in the 835 standard.

A control segment has the same structure as a data segment; the distinction is in the usage. The data segment is used primarily to convey user information while the control segment is used primarily to convey control information and for grouping data segments. A data segment corresponds to a loosely record in data processing terminology. The data segment begins with a segment ID and contains related data elements. Other definitions, such as data element types, may be found in ANSI ASC X12.6 Application Control Structure.

Implementation Considerations

This section covers implementation considerations, including the character sets used in the interchange of the transaction sets, with particular emphasis on the delimiters.

Basic Character Set

The selection that follows is designed to have representation in the common character code schemes of EBCIDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein my be used as long as a common mapping is available. Since the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z 0...9 "!" """ "&" "," "(" ")" "*" "+"

"," "-" "." "/" ":" ";" "?" "=" " " (Space)

Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified below.

a...z "%" "~" "@" "[" "]" "_" "{" "}"

"\" "|" "<" ">" "#" "$"

It should be noted that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears in other standards such as CCITT S.5. Use of the

U.S.A. graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the following table IA5 represents CCITT V.3 International Alphabet 5. Control characters must be able to translate from EBCDIC to ASCII.

Base Control Set

The base control set includes those that will not have a disruptive effect on most communication protocols. These are represented by:

Notation	EBCDIC	ASCII	IA5
BEL bell	2F	07	07
HT horizontal tab	05	09	09
LF line feed	25	OA	OA
VT vertical tab	OB	OB	OB
FF form feed	OC	OC	OC
CR carriage return	OD	OD	OD
FS file separator	1C	1C	1C
GS group separator	1D	1D	1D
RS record separator	1E	1E	1E

Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are represented by:

Notation	EBCDIC	ASCII	IA5
SOH start of header	01	01	01
STX start of text	02	02	02
ETX end of text	03	03	03
EOT end of transmission	37	04	04
ENQ enquiry	2D	05	05
ACK acknowledge	2E	06	06
DC1 device control 1	11	11	11
DC2 device control 2	12	12	12
DC3 device control 3	13	13	13
DC4 device control 4	3C	14	14
NAK negative acknowledge	3D	15	15
SYN synchronous idle	32	16	16
ETB end of block	26	17	17

Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data. Delimiters are specified in the interchange header and are not to be used in a data element value elsewhere in the interchange. Due to potential conflicts with either the data elements or with the special needs of transmission and device control, the historically used elements have caused problems. The following recommendations are provided for the delimiter character selection. These recommendations are in decreasing order of preference as indicated below. It is recommended that you select data element (and subelement) separators and a segment terminator that are not part of the business data, do not conflict with the communication protocol and are printable characters in order to make error resolution easier.

Data Element Separator & Subelement Separator		
Preferred	Acceptable	Should not be used
* (Asterisk)	control char extend control char * (Asterisk)	uppercase letter digit lowercase letter
> (Greater Than)	(Vertical Bar) ~ (Tilde) ^ (Circumflex)	special char US

Terminator		
Preferred	Acceptable	Should not be used
~ (Tilde)	control char extend control char FS (File Separator) (Vertical Bar) ~ (Tilde) ^ (Circumflex)	uppercase letter digit lowercase letter special char NL

These recommendations are made for the following reasons. The carriage return (CR) and line feed (LF) are usually used as a special device control characters. The new line character does not have a clear mapping between character sets. The uppercase letter, digit, and lowercase letter have too high a chance of conflict with the data.

Many of the special char may also appear in the data. The problem with many of the characters in control char and extend control char is that they have either special device control characteristics or are used for transmission control.

Whenever possible choose data element (and subelement) separators and a segment terminator from the "Preferred" box.

C. Business Transaction Structure
Definitions and Concepts

Basic Structure

The X12 standards define commonly used business transactions in a formal, structured manner called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of: a unique segment ID; one or more logically related simple data elements or composite data structures, or both, each preceded by a data element separator; and a segment terminator.

Composite data structures are composed of one or more logically related component data elements, each, except the last, followed by a component element separator. The data segment directory entry referenced by the data segment ID defines the sequence of simple data elements and composite data structures in the segment and any interdependencies that may exist. The composite data structure directory entry referenced by the composite data structure number defines the sequence of component data elements in the composite data structure.

A data element in the transaction set header identifies the type of transaction set. A functional group contains one or more related transaction sets preceded by a functional group header control segment and terminated by a functional group trailer control segment.

Delimiters

The delimiters consist of two levels of separators and a terminator. The delimiters are an integral part of the transferred data stream. Delimiters are specified in the interchange header and are not to be used in a data element value elsewhere in the interchange with the exception of their possible appearance in the binary data element.

Data Element

The data element is the smallest named unit of information in the 835 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.

Numeric

A numeric is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

The data element dictionary defines the number of implied decimal positions. The representation for this data element type is "Nn" where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point. If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement in a fixed length element such as ISA. The length of a numeric type data element does not include any negative sign.

FOR EXAMPLE: Value is "-123.4". Numeric type is N2 where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "-12340". The length is 5 (note padded zero).

Decimal Number

A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R". Leading and trailing zeroes should not be used in "R" elements. Additionally, when sending monetary amount information including cents, the decimal point is only required if cents are involved. For example, use 25 instead of 25.00 for $25, use 25.1 instead of 25.10 for $25.10.

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. As mentioned above, trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include any negative leading sign or decimal point.

Identifier

An identifier data element always contains a value from a predefined list of values that is maintained by the X12 Committee or some other body recognized by the X12 Committee or a body delegated to maintain the values set by the X12 Committee. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID".

String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN".

Date

A data element is used to express the ISO standard date in YYMMDD format in which YY is the year in the century (00 to 99), MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT".

Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is "TM".

Data Element Reference Number

Data elements are assigned a unique reference number to locate them in the data dictionary. For each data element, the dictionary specifies the name, description, type, minimum length, and maximum length. For ID data elements, the dictionary lists all code values and their descriptions or references where the valid code list can be obtained.

Data Element Type

The following types of data elements appear in the dictionary.

Type	Symbol
Numeric	Nn
Decimal	R
Identifier	ID
String	AN
Date	DT
Time	TM

Data Element Length

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric and decimal elements.

Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator, and a segment terminator. Data segments are defined in the "implementation detail" in Section IV. This subsection defines each segment including the segment's name, purpose, and identifier, and the composite data structures and/or data elements that it contains.

Data Segment Identifier

Each data segment has a unique two- or three-position identifier. This identifier serves as a label for the data segment.

Data Elements in a Segment

In defining a segment, each simple data element or composite data structure within the data segment is further characterized by a reference designator and a data element reference number or composite data structure reference identifier. Simple data elements and composite data elements may have additional attributes, including a condition designator and a semantic note designator.

Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure. For example, the first simple element of the SVC segment would be identified as SVC01 because the position count does not include the segment identifier, which is a label. If the second position in the SVC segment were occupied by a composite data structure that contained three component data elements, the reference designator for the second component data element would be SVC02-02. This is the case in versions of the standard from version 3040 and on (i.e., the SVC segment contains a composite element).

Condition Designator

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

Mandatory Condition

The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. Mandatory conditions are specified by condition code "M".

Condition	Requirement
(M) Mandatory	The designated simple data element or composite data structure must be present in the segment (presence means a data element or composite structure must not be empty). If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.

Relational Conditions

Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code and the identity of the subject elements. A data element may be subject to more than one relational condition. The definitions for each of the <condition_code> values are:

Condition	Requirement
(P) Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
(R) Required	At least one of the elements specified in the condition must be present.
(E) Exclusion	Not more than one of the elements specified in the condition may be present.

(C) Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
(L) List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Semantic Note Designator

Simple data elements or composite data structures may have a designation that indicates the existence of a semantic note. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements. Semantic notes are considered part of the relevant transaction set standard.

Semantic Note (Z)	A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.

Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set headers segment, one or more data segments in a specified order, and a transaction set trailer segment.

Transaction Set Header and Trailer

The transaction set header and trailer segments are constructed as follows:

Transaction Set Header (ST)
Data Segment Group
Transaction Set Trailer (SE)

The transaction set identifier, uniquely identifies the transaction set. This identifier is the first data element of the transaction set header segment. The value for the transaction set control number, in the header and trailer control segments must be identical for any given transaction. The value for the number of included segments,which is part of the SE segment, is the total number of segments in the transaction set including the ST and SE segments.

Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".

Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Unbounded Loops

In order to establish the iteration of a loop, the first data segment in the loop shall appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1".

There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop.

If unbounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop shall not start with the same segment as its immediate outer loop. For any segment that occurs in a loop and in the parent structure of that loop, that segment must occur prior to that loop in the parent structure or subsequent to an intervening mandatory segment in the parent structure (parent structure is composed of all segments at the same level of nesting as the beginning segment of the loop).

Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start (LS) segment to appear before the first occurrence and a loop end (LE) segment to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments shall be suppressed. The requirement designator on the LS and LE segments must match the requirement designator of the beginning segment of the loop.

A bounded loop may contain only one loop structure at the level bracketed by the LS and LE segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop must end before or on the same segment as its immediate outer loop.

Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are to be applied to a data segment in that usage: a requirement designator, a position in the transaction set, and a maximum occurrence.

Data Segment Requirement Designators

A data segment shall have one of the following requirement designators indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

Designator	Requirement
(M) Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
(F) Floating	This is used only for the NTE segment that may appear anywhere in the transaction set between the transaction set header and the transaction set trailer. Its use is not recommended.
(N) Not Used	This is an optional requirement in the ANSI ASC X12 standard which is not used in the Medicare Part B implementation of the standard.

Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional and floating requirement designators of the segments, this positioning must be maintained.

Data Segment Occurrence

A data segment may have a maximum occurrence of one, or a finite number greater than one, or an unlimited number.

Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number, in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets, is the total number of transaction sets in the group.

Control Segment

A control segment has the same structure as a data segment but is used for transferring control information rather than application information.

Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure.

The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop.

Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

Relations among Control Segments

The control segments of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS	Functional Group Header, starts a group of related transaction sets.
ST	Transaction Set Header, starts a transaction set.
LS	Loop Header, starts a bounded loop of data segments but is not part of the loop.
LS	Loop Header, starts an inner, nested, bounded loop.
LE	Loop Trailer, ends an inner, nested, bounded loop.
LE	Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
SE	Transaction Set Trailer, ends a transaction set.
GE	Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

D. Electronic Funds Transfer (EFT)

1 The Abbreviated 835

There may be situations when an 835 transaction set is used in lieu of an alternate automated clearing house (ACH) transaction to notify banks that payment is being sent through banking networks without remittance information (EFT only). In such cases, an abbreviated 835 can be sent. [Section IV presents all the segments that can be used in the 835 for Carriers and necessary enveloping structures.] The abbreviated 835 and envelope would include the following segments, which must be used in this sequence:

0-010-ISA, 0-020-GS, 1-010-ST, 1-020-BPR, 1-040-TRN, 1-060.A-REF, 1-060.B-REF, 1-080.A-N1, 1-080.B-N1, 3-020-SE, 4-010-GE, and 4-020-IEA.

An option exists to send other segments from Table 1 in sequence, such as 1-100-N3 or 1-110-NR after 1-080-N1. Table 2 information or the PLB segment from Table III would not be transmitted in an abbreviated 835.

It is also important to ensure that a Carrier obtains all the necessary data from all banks participating in an EFT transaction. This additional data must be in the file of the provider receiving the EFT, and should be properly reflected in every BPR segment each time an EFT is sent. For example:

Data Element	EFT Requirement
BPR01	Select "D" = "Payment only";
BPR04	DO NOT Select "CHK" = "Paper check."

BPR has a total of 16 data elements. Data elements 01-04 and 16 are required whenever an 835 is sent by Carriers. However, BPR05-10 and 12-15 are specifically applicable to an EFT and/or remittance information being sent through financial institutions.

2 HCFA Policy

HCFA is committed to offering all qualified Medicare providers the option of receiving payments (EFT) and remittance advices (ERA) electronically. Providers are encouraged to contact their carriers for additional information regarding Medicare's electronic payment environment.

Medicare's commitment to EFT/ERA will offer several advantages to Carriers and providers. Advantages for carriers include: the reduction of administrative expenses associated with the generation of checks and hard copy remittances, the certainty of delivery of payment, and the elimination of the need to mail checks and remittances. For providers, advantages include: better cash management forecasting, timely delivery of payment and remittance information, elimination of the burden associated with depositing checks, and reduction of clerical costs for account reconciliation.

Carriers will effectuate provider EFTs through the Automated Clearing House (ACH). The ACH was designed as a computer-based alternative to the existing check clearance system. The ACH facilitates the collection and settlement of check-like payments. Over 10,000 financial institutions in the United States are ACH members. For EFT, HCFA/carriers will only cover the cost of transmission of the EFT through their banks to the ACH. 835 data may be also sent through the banking network at a provider's request as long as beneficiary-specific data are not viewed or manipulated in the process.

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A. Introduction to the 835

This section provides information for the actual use of the 835 for carriers to transfer remittance information or payments to a provider electronically.

This implementation is based upon the X12 Standards Draft Version 3 Release 5, subrelease 1 published in February of 1995. A copy of the standards document is available through:

Data Interchange Standards Association, Inc.
1800 Diagonal Road, Suite 200
Alexandria, Virginia 22314-2852
(703) 548-7005

B. 835 Philosophy

The ANSI ASC X12 835 DSTU (draft standard for trial use) presents the format and establishes the data contained in the "Health Care Claim Payment/Advice" transaction set within the context of the EDI environment. This 835 is intended to be used by payers, providers, and their respective banks to make a payment, send an explanation of Medicare payment, or do both activities. In at least one medical specialty, dentistry, the 835 is also used to give pre-authorization for payment prior to the delivery of services.

On the whole, however, the 835 is used to transmit payment and data needed for posting subsequent to adjudication of a claim. Medicare uses the 835 exclusively to transmit payments and information needed for posting, including reporting denials of claims and claims that contain a zero payment amount.

While the NSF remittance format can convey information appropriate to multiple vouchers/checks, the 835 contains remittance advice information for only one voucher/check. The 835 is equivalent to the NSF using batch level (200 record) information.

C. 835 Balancing

FINANCIAL BALANCING OF VERSION 3051
835 ELECTRONIC REMITTANCE ADVICE
FOR MEDICARE

Basics of Balancing the 835 Standard

The concept of balancing is essential to assuring uniform implementation of the 835 among ALL health care payers. In short, balancing means for every Release 3051 835 implementation:

At the line/service and claim level of remittance detail, when data is present, the difference of all billed/submitted charges and the net of all financial adjustments MUST equal the given payment amount at that level.

There are distinct locations for the subtotals of all billed/submitted charges and payment at these two detail levels:

Billed/Submitted Charges:

Line/service	Element SVC02 in the SVC Segment in the SVC Loop in Table 2
Claim	Element CLP03 in the CLP Segment in the CLP Loop in Table 2

Payment Amount:

Line/service	Element SVC03 in the SVC Segment in the SVC Loop in Table 2
Claim	Element CLP04 in the CLP Segment in the CLP Loop in Table 2

However, in total there are three detail levels where financial adjustments are present and must balance: line/service, claim, and provider/transaction; and these adjustments are placed in three distinct locations in the 835 standard:

Line/service	CAS Segment(s) in the SVC Loop in Table 2
Claim	CAS Segment(s) in the CLP Loop in Table 2
Provider	PLB Segment(s) in Table 3

Finally, the balancing routine aggregates financial information up from the line/service level, to the claim level, and then to the provider/transaction level in order to equal a SINGLE payment amount in Element 02, BPR Segment, Table 1 for a SINGLE 835 transmission.

Because the balancing routine makes calculations on all numeric data carried in the CAS and PLB adjustment segments no purely informational data is carrier in the CAS and PLB adjustment segments.

The numeric value for total provider payment in element BPR02 cannot be less than zero. There are, however, situations where the total claim payment and provider level adjustments would be less than zero unless a counterbalancing adjustment is introduced to bring the transaction total to zero. In such situations, the PLB adjustment code ‘BF’ is used to indicate a negative balance amount which is used to balance the current transaction to zero and which will be carried forward and applied in a subsequent payment cycle. Sine all numeric values occurring in adjustment segments are considered to be negative in value, the numeric string of a monetary amount element following the ‘BF’ adjustment code will be preceded by a minus sign in order to balance the 835. When received, providers must retain the ‘BF’ coded negative balance amount in their accounting systems until it has been disbursed in subsequent 835 remittance cycles.

Situations will occur when a negative balance amount is not entirely disbursed in a single subsequent payment cycle. In these situations the 835 does not provide explicit notification to providers of the negative balance amounts which will be carried forward to subsequent payment cycles. Providers are expected to calculate the negative balance amounts to be carried forward in their accounting systems by subtracting the negative balance amount applied in the current 835, identified by a ‘CO’ adjustment code, from total outstanding negative balance amount(s) identified in previously received PLB segments with ‘BF’ coded monetary amounts. Since ‘CO’ coded monetary amount elements are used to identify the amount of outstanding negative balances applied in the current 835, no sign is used in the monetary amount element numeric string because positive numeric values in the CAS and PLB adjustment segments are SUBTRACTED from any positive numeric value calculated from the total claim payments, i.e., CLP04(s), and PLB adjustments in the providers favor, i.e., those, excluding ‘BFs’, which carry a negative sign in a monetary amount element.

Medicare Net Reimbursement

Representation of the Medicare net reimbursement amount for claims transmitted in an 835 has posed questions in the past. Per claim, Medicare net reimbursement should equal total payment excluding any interest which may have been paid by Medicare contractors to their providers when the processing of "clean" Medicare claims exceeded certain time frames set forth in law.

CLP04 IS TO BE USED SOLELY TO EXPRESS MEDICARE NET REIMBURSEMENT FOR THE CLAIM. This clarification has been effected through the following steps designed to minimize change for both Medicare Part A and B communities:

1. Claim payment reason code "85" is NEVER to be used in CAS segments in Medicare-compliant 835 transmissions to express interest paid to providers when the processing of "clean" Medicare claims has exceeded certain timeframes set forth in law.

2. The per-claim interest amount, when present, will be provided in a claim-level AMT segment (2-062-AMT02, CLP Loop). Since AMT segments are not part of the 835 balancing routine, these amounts are informational only and do not enter into total payment at the claim level (Element CLP04).

3. The total interest paid to a provider for an entire 835 transmission (under the circumstances described in 1., above) will be provided in a monetary amount element in the PLB segment (PLB04/06/08/10/12/14). The PLB reference number elements (PLB03/05/07/09/11/13) preceding each amount representing interest will begin with a prefix identifying the following amount as interest:

   For Part B, this is the two-character prefix "IN".

   It is ONLY in the PLB segment that this interest paid to providers will be taken into account for financial balancing of the 835.

Formulas for Balancing

With the clarification regarding Medicare net reimbursement made above, the following formulas depicting the balancing algorithms for the 835 used through the health care industry are now fully applicable to both Parts A and B of Medicare.

Balancing with Service/Line Data

1. SVC03 = SVC02 - (sum of all line level CAS03/06/09/12/15/18)

2. CLP04 = CLP03 - (sum of all line AND claim level CAS03/06/09/12/15/18)

3. BPR02 = (sum of all CLP04) - (sum of all PLB04/06/08/10/12/14)

Balancing in the Absence of Service/Line Data

1. CLP04 = CLP03 - (sum of all claim level CAS03/06/09/12/15/18)

2. BPR02 = (sum of all CLP04) - (sum of all PLB04/06/08/10/12/14)

Note that for an abbreviated 835, which may have no adjustments, BPR02 still provides the total payment amount for the transmission.

Note also, that adjustments occurring at the service/line levels must not be repeated at the claim level.

Specific Medicare Uses of the CAS Segment in Release 3051 of the 835 Standard

Claim adjustment reason code values should be used exclusively to represent financial adjustments. [A complete list of claim payment adjustment reason code values are given in Appendix C of this guide.] At earlier points in the development of the 835, there was less agreement and direction on what type of adjustments those code values should represent. Consequently, there have been code values on the reason code list which represented either summary or adjudication information that did not have immediate financial effects.

Medicare Secondary Payer (MSP) Adjustments in CAS Segments

In order to show patient liability and provider liability on a remittance notice when MSP applies, carriers must follow four steps to determine the amount of Medicare payment when another payer is primary to Medicare:

1. Deduct the primary payment from the lower of the billed amount for the claim or the amount a provider is obliged to accept in full (OTAF amount which applies to Worker's Compensation or liability cap or in a managed care arrangement);

2. Subtract any outstanding Medicare deductible from the Medicare allowed amount for the services on the claim. Multiply the result by 80%;

3. Subtract the primary insurer's payment from the greater of the primary payer's allowed amount or the Medicare allowed amount;

4. Pay the lesser of the amount in 1, 2, or 3.

To eliminate confusion and allow a provider to balance the transaction against the billed amount, do not print any deductible, coinsurance or other adjustment reason code with a PR (patient responsibility) group code if the amount of the primary payment exceeded the amount of the patient's liability. If the patient liability was not fully satisfied by the primary payment, show the balance of any outstanding deductible, coinsurance and/or other applicable PR adjustment. Show the difference between the Medicare payment in step 4 and the Medicare allowed amount from step 2 as the primary payer amount (835 reason code 71 with group OA) on the remittance notice.

For example, a provider bills the primary insurer $1000 for a claim. The primary payer allows $750 for the claim but has an unsatisfied $150 deductible. Medicare allows $500 for that same claim and $100 of the beneficiary's Medicare deductible is still outstanding. Following the four steps:

1. $1000 (billed) - $600 (primary payment) = $400

2. ($500 [Medicare allowed] - $100 [outstanding Medicare deductible]) X .80 (coinsurance reduction) = $320

3. $750 (primary's allowed amount) - $600 (primary's payment) = $150

4. Medicare payment = $150 (the lowest of 1, 2, and 3)

If there are two or more payers primary to Medicare, the 835 will provide only the total of the primary payments as used to offset the billed amount and to determine the Medicare payment in the CAS segment with reason code 71.

Although the MSPPAY module currently calculates Medicare payment at a claim level rather than a line level, patient and provider liability must be shown at a line level to enable the provider to know the reason for any denial or reduction on individual services and to allow the beneficiary and provider to know how much of their liability remains after offset by the primary payment. The standard paper and electronic remittance notices are designed to allow a provider to balance the amount of the payments and the adjustments for each line item against the amount billed for that line item.

Until the MSPPAY module is corrected to issue line level calculations in multi-line claims, you must apportion the total amount of the claim-level Medicare payment calculated by the MSPPAY module toward those services covered by Medicare. You must also apportion the total amount of the claim level primary payment toward those services covered by the primary payer to determine the liability of the beneficiary and the provider to be reported on a paper or electronic remittance notice. You can usually use the primary's allowed amounts to determine which services it has covered. In the absence of information from a primary payer that enables you to determine if any services were not covered by that payer, assume that the primary payment was for all of the billed services when apportioning the payment.

When apportioning a primary's payment toward the amounts for which a beneficiary or provider is liable, you must always apportion in the following hierarchy: beneficiary deductible; beneficiary coinsurance; any other amount for which the beneficiary is liable as signified by a PR group code and which is covered by Medicare; any amount for which a provider is liable as signified with a CO group code and which is covered by Medicare; any amount for which a beneficiary is liable as shown with a PR group code but which is not covered by Medicare; and any amount for which a provider is liable as shown with a CO group code but which is not covered by Medicare.

The primary's payment can only offset the provider's liability to the extent that the primary's allowed amount is higher than the Medicare allowed amount. You may not make a CO A3 (Medicare Secondary Payer liability met) adjustment if the primary's allowed amount is less than the Medicare allowed amount.

Provider Adjustment Segment Theory

The PLB segment is designed to convey provider level adjustments that do not pertain to any given claim or service within the transmitted 835 transaction. The PLB segment within this implementation guide uses provider adjustment reason code elements (PLB03, 05, 07, 09, 11 and 13) to provide three pieces of information about these adjustments. As with the CAS segment, the PLB segment must only be used to report adjustments to payment. Informational data which does not impact the payment amount must not be reported in the PLB segement. The first piece of information, filling the first two positions in the element, is a prefix used to identify to reason for the adjustment/deduction:

AP = Advance Payment
BF = Balance Forwarded
LP = Student Loan Repayment
OF = Offset
IL = IRS Levy
WH = IRS Withholding
RF = Refund
LF = Late Filing Reduction
IN = Interest
AJ = Adjustment

The third to nineteenth positions of such elements should convey the financial control number (FCN) when assigned to an adjustment by a payer. The remaining positions (20-30) may be used to identify the health insurance claim (HIC) number of the patient whose original claim was overpaid when an offset adjustment reason is given. Only one HIC may be shown in this segment. The FCN is required, but use of the HIC is optional.

Signing of Adjustment Amounts

In an 835 transmission, financial adjustments, if present, must be transmitted in either the line or claim level CAS segment or the PLB segment as described above. It is important to remember that POSITIVE amounts in these locations represents REDUCTIONS to payments, and NEGATIVE amounts represent INCREASES to payments.

D. Reversals and Corrections

In the case where a claim has been previously paid in error, the recommended method for error correction of a claim which has been processed and paid would be to reverse the original claim payment and resend the corrected data. This will assist providers in controlling the accuracy and integrity of their receivables systems. Understanding that many payer claim adjudication systems cannot handle this type of correction methodology on their existing applications, an alternate method has been developed. While providers will have more balancing and control problems with the alternate method, it is the reality of where payer's claims adjudication systems are today. It is expected that the alternate method will cease to be offered in some future version of this guide. Therefore, we highly recommend that the preferred method be used in all instances, if possible. Be aware that handling of reversals internal to the 835 may cause system changes that should be addressed as part of the implementation plan.

Example of Reversal:

In the original Provider payment, the reported charges were:

Submitted charges	$100.00
Disallowed amount	$-20.00
Coinsurance	$-16.00
Deductible	$-24.00
Payment amount	$ 40.00

Original Payment

CLP*1234567890*1*100*40*40*MB*9602M1234567~
CAS*PR*1*24**2*16~
CAS*CO*45*20~

The payer found an error in the original adjudication of the claim that required a correction. In this case, the disallowed amount should have been $40.00 instead of the original $20.00, the coinsurance amount should have been $12.00 instead of $16.00 and the deductible amount remained the same.

Recommended Reversal

The preferred method would be to reverse the original payment, restoring the patient accounting system to the pre-posting balance for this patient. Then, the corrected claim payment is sent to the provider for posting to the account.

It is anticipated that the provider will have the ability to post these reversals electronically, without any human intervention.

Reversal of the original claim payment is accomplished with a CLP02 value of "22", Reversal of Previous Payment, and appropriate adjustments in a CAS Group value of CR, Corrections and Reversals. All original charge, payment and adjustment amounts are negated.

CLP*1234567890*22*-100*-40*MB*9602M1234567~
CAS*CR*1*-24**2*-16**45*-20~

Note: The reversal does not contain any patient responsibility amounts.

The corrected claim payment is then provided and reported on the 835 as:

CLP*1234567890*1*100*24*36*MB*9603M1234567~
CAS*PR*1*24**2*12~
CAS*CO*45*40~

Alternate Reversal

In this correction, the net result is to take $16.00 from the provider (proper payment of $24.00 minus the original payment of $40.00 equals $-16.00) with a single claim loop. All of the corrected adjustments are shown as part of a single corrected payment, the $24.00 deductible, $12.00 for coinsurance and $40.00 for the disallowed amount. An additional adjustment for the original payment is conveyed as an Other Adjustment.

Please note that the provider will have to handle this item as exception processing and it may require human intervention.

This reversal method is identified to the provider by a CLP02 value of "22", Reversal of Previous Payment, and an original charge amount which is positive.

CLP*1234567890*22*100*-16*36*MB*96031234567~
CAS*PR*1*24**2*12~
CAS*CO*45*40~
CAS*OA*B13*40~

Any adjustments that had been part of the original claim payment, and are not part of the corrected payment are assumed to have been changed to $0.00 as a result of the change in payment.

NOTE: 1 - Both of the above methods must result in an 835, and cannot cause the total payment amount to become negative.

2 - The above examples did not provide service line detail. If there was service line detail on the original payment, then the reversal should apply the same reversal logic to the claim and service levels.

E. Service Level Use of AMT Segments in this Release

The 3051 version of the 835 standard now includes AMT, QTY and LQ segments. Version 3030 guide used REF segments at the service line levels to pass on certain pieces of information: place of service, units of service, Medicare allowed amount, performing provider ID, facility/supplier ID and informational messages. However, in version 3051, use:

1. REF segments to report place of service, performing provider ID, and facility/supplier ID.
2. AMT to report Medicare allowed amount and late filing reduction.
3. QTY to report units of service.
4. LQ to report REF-line remark codes informational messages.

F. Procedure Code Bundling

Procedure code bundling occurs when a payer believes that the actual services performed and reported for payment in a claim can be represented by a different group of procedure codes. The preferred grouping usually results in a lower payment from the payer. Bundling will occur when two (2) or more reported procedures are going to be paid under only one procedure code.

Whenever this occurs, it is important to accurately represent this information back to the payee in order to facilitate automatic entry to a patient accounting/accounts receivable system. In the interest of standardization, payers should perform bundling in a consistent manner.

When bundling, the remittance advice must report back all of the originally submitted procedures. All procedures must be reported as paying on the changed (bundled) procedure code, and reference the original submitted code in the SVC segment, position 06. This procedure may result in a payment exceeding the original charge for the first service line. This would be reflected by a CAS segment containing reason 94 (Processed in Excess of Charges) and a negative amount, increasing the payment as appropriate. This increase should allow the provider to identify the allowed amount as the original procedure charge plus the CAS code 94 amount. The other procedure or procedures should be reported as originally submitted, with an adjudicated code of the bundled procedure code and a CAS Claim Adjustment Reason Code of 97 (Payment is included in the allowance for the basic service), and an adjustment amount equal to the submitted charge.

Bundling Example:

Dr. Smith submits procedure code "A" and "B" for $100.00 each, performed on the same date of service.

The adjudication system screens the submitted procedures and notes that procedure "C" covers the services rendered by Dr. Smith on that single date of service. The maximum allowed amount for procedure "C" is $120.00. The patient's coinsurance amount for procedure "C" is $20.00. The patient has not met their $50.00 deductible.

The following segments would be used in an 835 transaction to report this adjudication (date and other segments not necessary to bundling have been left out of the example):

CLP*123456789*1*200*50*70*12~
CAS*PR*1*50~

SVC*HC>C*100*100**1*HC>A~
CAS*CO*94*-20~
CAS*PR*2*20~

SVC*HC>C*100*0**1*HC>B~
CAS*C0*97*100~

G. LX LOOP

Assigned and Unassigned Claims:

Assigned and unassigned claims will be batched in separate Table 2 LX Loops. When a provider receives batched assigned and unassigned claims information in the same 835, first write an LX loop for all of the assigned claims. Use LX01 = 1 to identify the claims as assigned. Then, write a second LX loop for unassigned claims. Identify those with LX01 = 0.

For unassigned claims, use a CAS segment with a "PR" group code, and a claim adjustment reason code of "100" (Payment made to patient/insured/responsible party).

H. Medicare B 835 Implementation Guide Organization and Use

About this Section

The Implementation Set, Summary and Detail presented in this section form the core of the 835 implementation guide for carriers. Carriers and their providers must follow these instructions when implementing the 835 for use in the Medicare Part B Program. No part of this text is to be modified without the knowledge and consent of HCFA.

Medicare requirements are more specific than those of X12 in many cases. The program in which this guide is written is specifically designed to highlight gradations of requirements between X12 and HCFA. Requirements of the Medicare program appear in boldface in Section IV. Boldface text should not be altered in any way by carriers or providers. Medicare requirements presented in boldface may represent a range of HCFA decisions, including standing Medicare policies or HCFA-imposed selections of X12 codes made to limit code choices to those appropriate to Medicare Part B.

Implementation Guide Format

HCFA's implementation guide was designed to provide all technical information required for each segment in one section. This avoids having to move to other sections to obtain data element number, attributes, etc. The following describes how to read the implementation tables and detail.

Implementation Set

The Implementation Set is an overview of the entire 835 transaction as used in the Medicare Part B implementation guide. The transaction is divided into five tables numbered 0 to 4. Tables 0 and 4 are not actually part of the 835 transaction. They represent the opening and closing "envelopes" that enclose X12 transaction sets (the 835, 837, etc.). Table 1 opens the 835, and provides information on the sender, receiver and payee (Loop N1) of the 835, as well as their banks, version numbers and other things the sender and receiver need to share to transmit the 835 successfully.

Table 2 provides claim-level information on the payment being described in the 835 being sent in the CLP loop, and service-level information in the SVC loop. [Loops link segments that share some commonality; they work to identify a payee, provide claim-level data, etc.] The LX loop facilitates the repetition of segments at claim-level and service-level within Table 2. Table 3 gives information on provider-level offsets and closes the 835 transaction. A sample of the columns and their contents from Table 2 is reviewed below.

TABLE 2

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
		Loop ID - CLP [1]				>1 |[2]
	010	CLP	Claim Level Data	M	1	|
N	020.A	CAS	Medicare C.-Level Adj.	M	1	|
[3]	[4]	[5]	[6]	[7]	[8]	

where:

[1] The "Loop ID" identifies the loop in which related segments are grouped.

[2] The number of times the loop can be repeated.

[3] Notes ("Nte") follow the table specifying relational conditions, general explanation, etc.

[4] "Pos." gives sequential position number for the segment within the 835 based on the ANSI ASC X12 835 positions.

[5] Under the first part of "Seg. Name", the official ANSI ASC X12 acronym for each segment used in the 835 is given.

[6] The name of each segment used in the Medicare Part B implementation of the 835 is given in the second part of "Seg. Name".

[7] "Req." is requirement designator, and gives a letter indication the requirement status for each segment: M =Mandatory, O = Optional, C = Conditional. N is not really a requirement status, but instead stands for “not used," which means this particular segment is not used for Medicare Part B implementation of the ANSI ASC X12 835 transaction set.

[8] "Max. Use" gives the maximum number of times each segment can be used in an 835. Most of these entries are 1 or greater than (>) 1.

Implementation Summary

The Implementation Summary contains more specific information than the Implementation Set: it lists each element within the segments. Again, the beginning of the CLP loop is used to walk through this table.

TABLE 2

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
			Begin Loop CLP	Max. Use:	>1
			[1]	[2]	
010	CLP	Mandatory	Claim Level Data	Max. Use: 1 [7]	
	CLP01	Mandatory	Patient Control Number	1028	AN 1 38
[3]	[4]	[5]	[6]	[8]	[9] [10]

where:

[1] ”Begin Loop" identifies the start and name of the loop in which the related segments are grouped.

[2] "Max. Use" gives the number of times the loop can be repeated.

[3] "Positn." gives sequential position number for the segment within the 835 based on the ANSI ASC X12 835 positions.

[4] "Seg+E" gives the unique ANSI ASC X12 identifier that serves as a label for each segment when the segment begins, and then gives the identifier with the element number for each element within that segment.

[5] "Requirement" spells out the requirement status for each segment and each element.

[6] "Segment & Element Name" provides the names of either a segment or an element within a segment.

[7] At this level, "Max. Use" gives the number of times a segment can be repeated.

[8] "Ele#" provides the ANSI ASC X12 official reference number for your convenience when cross-referencing with X12 documentation.

[9] "Attributes" gives characteristics of the elements.
The first of these characteristics is data types.
These data types are defined as follows:

AN Alpha-numeric (string) - any printable character, with the exception of the data element and segment separators. Significant characters must be left justified. Trailing spaces should be suppressed.

ID Identifier - An identifier data type must contain a value from a list maintained by ASC X12 or another specified external body. The applicable values for usage in the Medicare Part B implementation are shown in the Implementation Summary in bold and quotation marks when possible.

DT Date - The format for the Date data type is YYMMDD.

Nn Numeric - The numeric data type is symbolized by an "N" followed by a single numeric character. The numeric character, symbolized by the "n" identifies the number of positions to the right of the implied decimal point. The number is identified to be positive unless an explicit leading minus sign is used to indicate a negative number. The minimum and maximum lengths of the numeric character are calculated without counting the minus sign.

R Decimal - This data type is used to represent numeric data where the decimal point is not present. Integer values are sent without a decimal point. The decimal point is required for fractional values. The number is identified to be positive, unless accompanied by a leading minus sign. The minus sign and decimal point are not counted when determining the length of the number. Leading zeroes or plus signs are suppressed.

TM Time - The Time data type is expressed in a 24 hour clock format, HHMMSSd..d. "d..d" represents the numeric expression of decimal seconds.

NOTE: Please reference section III for a more complete description of data types.

[10] "Attributes" then gives the minimum (the least number of characters) and maximum (the most number of characters) length of each element when used. Mandatory elements must always be used and filled to the minimum required length.

Implementation Detail

The Implementation Detail reiterates and supplements information contained in the Implementation Set and Summary. The columns and their contents are described below.

Medicare B 835 Health Care Claim/Payment Advice 2-010-CLP [1]

[2]
X12 Segment Name: CLP Claim Level Data
Loop: CLP Repeat > 1
Max. Use: 1
X12 Purpose: To supply information common to all services of a claim.
Usage: Mandatory
Example: CLP*76543SMITH*1*500*200*100*MB*9702MI234567~
Comments: This is the first segment written for each claim.

Semantic Note: CLP03 is the amount of submitted charges this claim. [3]
Semantic Note: CLP04 is the amount paid this claim.
Semantic Note: CLP05 is the patient responsibility amount.
Semantic Note: CLP07 is the payor's internal control number.

Element Attributes	Data Element Usage	NSF Mapping
CLP01 1028 AN 1 38 M [4]	Claim Submitter's ID [5] Patient Control Number Identifier used to track a claim from creation by the health care provider through payment. Claim identifier originally assigner by the provider. It is carried through the payor's system and returned to the provider to allow account posting. If the Patient Control Number is not present on the incoming claim, enter a zero in this element. [7]	400-03, 450-03, 451-03, 500-03, [6]

where:

[1] Is the page header referencing the implementation of the transaction to the left and the table and segment position (2-010) and the segment identifier (CLP) to the right.

[2] The header for the segment itself, appearing at the beginning of each segment. Medicare-specific information is bolded. However, ANSI ASC X12 information is not over-written, so that if the X12 name differs from the Medicare name of the segment, two name lines will appear, the first being "X12 Name", the second being "Name" in bold. The purpose can also be repeated in this same fashion if the Medicare purpose is more specific than the "X12 purpose". "Loop", "Max. Use" and "Usage" (requirement status) have already been presented in the Set and Summary. The "Example" shows how the segment might look when received before translation. These examples tie into the sample 835 presented in Appendix B. It is

important to note that these examples have intentionally been kept simple and easy to understand, and therefore may not be complete illustrations of what would have to be transmitted in any given segment to adhere to Medicare Part B requirements. "Comments" provide additional insight into the use of this segment.

[3] "Semantic Note(s)" highlight the meaning of particular elements within the segment.

[4] "Element Attributes" again present characteristics of each element as were given before in the Summary, where:

CLP01 is the data element reference designator;
1028 is the X12 data element dictionary reference #;
AN is the data element type;
1 is the minimum data element length;
38 is the maximum data element length;
M is the requirement designator.

[5] "Data Element Usage" begins by giving the X12 and, if different, Medicare Part B name for a given element.

[6] In "NSF Mapping", the NSF fields that correspond to this 835 element are listed.

[7] Also under "Data Element Usage" appears the X12 definition of the element, and, if different, the Medicare definition follows in bold. In some cases, such as CLP02, code lists may be included in the definition under "Data Element Usage" if needed to fill the element. In other cases, if a code list is necessary but too long to reproduce within a given segment, it is referenced in the text. Unfamiliar code lists, unlike the common HCPCS procedure codes, which providers may not have immediate access to are given in appendices if they are too long to fit within a segment.

Additional Information on Separators and Acknowledgments

Data Element and Separators

ASC X12 standards allow for the usage of various characters as delimiters. The actual delimiters used in any specific interchange are determined in the envelope, specifically within the ISA segment. The ISA segment consists of all mandatory data elements, with fixed data length, i.e. the minimum and maximum are identical.

The data element separator and segment terminator used in the ISA determines the characters used throughout the entire data interchange defined by that ISA and its corresponding trailer segment, the IEA.

In the balance of the implementation guide, the "*" is shown as the data element separator, the ">" is shown as the subelement separator, and the "~" is shown as the segment terminator. This has been done for simplicity, and should not be construed as the only approach. Please reference Section III for a detailed delimiters and their recommended usage for Medicare Part B and the 835.

Functional Acknowledgments

The Medicare Part B implementation of the 835 will not utilize the X12 Functional Acknowledgment capability, since HCFA does not believe providers should be obligated to acknowledge receipt of each 835 to the sending carrier. Therefore, Element ISA14 always contains "0" and the TA1 is not supported. This does not preclude the use of the functional acknowledgment with other transactions.

However, every carrier and provider (sender and receiver) may choose to make an agreement of their own regarding functional acknowledgments. The ANSI ASC X12 997 transaction set has been designed to allow pairs of senders and receivers ("trading partners") to establish a comprehensive control function as part of their business exchange process.

This acknowledgment process between trading partners facilitates control of multiple interchanges (batches) amongst multiple pairs of trading partners. There are many EDI implementations that have incorporated the acknowledgment process, for control purposes, in all of their electronic communications.

The 997 transaction is typically utilized as a functional acknowledgment to a previously transmitted interchange. Many translators can automatically generate this transaction set through parameter settings. Additionally, translators will automatically reconcile acknowledgments to interchanges. The benefit to this process is that the sending trading partner (in this case, the carrier) can determine if the receiving trading partner (the provider or designated agent) has received the 835 through reports that can be generated by the translator software to depict interchanges that have not been acknowledged.

As with any information flow, an acknowledgment process can be essential. If an "automatic" acknowledgment process is desired between trading partners, then the 997 is recommended.

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835 Health Care Claim Payment/Advice

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

TABLE 0

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
010	**ISA Interchange Control Header**	**M**	**1**	
020	**GS Functional Group Header**	**M**	**1**	

TABLE 1

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
010	**ST Transaction Set Header**	**M**	**1**	
020	**BPR Beginning Segment for Payment Order**	**M**	**1**	
030	**NTE -**	**N**	**0**	
C 040	**TRN Trace**	**M**	**1**	
C 050	**CUR -**	**N**	**0**	
060.A	**REF Implementation Guide**	**M**	**>1**	
060.B	**REF Receiver Identification**	**C**	**>1**	
070	**DTM Carrier Cycle Date**	**M**	**>1**	
	LOOP ID - N1			**200**
C 080.A	**N1 Payer Name**	**M**	**1**	
C 080.B	**N1 Payee Identification**	**M**	**1**	
090	**N2 -**	**N**	**0**	
100	**N3 -**	**N**	**0**	
110	**N4 -**	**N**	**0**	
120	**REF -**	**N**	**0**	
130	**PER -**	**N**	**0**	

TABLE 2

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
	LOOP ID - LX			>1
N 003.A	**LX Loop Indicator**	**C**	**1**	
N 003.B	**LX Loop Indicator**	**C**	**1**	
005	**TS3 -**	**N**	**0**	
007	**TS2 -**	**N**	**0**	

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
	LOOP ID - CLP			>1
010	**CLP Claim Level Data**	**M**	**1**	
N 020	**CAS Claim-Level Adjustments**	**C**	**99**	
030.A	**NM1 Patient Name**	**M**	**9**	
030.B	**NM1 Crossed Over/Transferred**	**C**	**9**	
030.C	**NM1 Crossed Over/Transferred**	**C**	**9**	
033	**MIA -**	**N**	**0**	
035	**MOA Medicare Adjudication Remarks**	**M**	**1**	
040	**REF Reference Numbers**	**N**	**0**	
050	**DTM Date of Receipt**	**M**	**9**	
060	**PER -**	**N**	**0**	
062	**AMT Monetary Amount**	**C**	**20**	
064	**QTY -**	**N**	**0**	
	LOOP ID - SVC			999
070	**SVC Claim Service Line Data**	**M**	**1**	
N 080.A	**DTM Service Date(s)**	**M**	**9**	
N 080.B	**DTM Service Date**	**C**	**9**	
N 090	**CAS Line-level Adjustments**	**C**	**99**	
100.A	**REF Place of Service**	**M**	**99**	
100.B	**REF Performing Provider ID**	**C**	**99**	
100.C	**REF Facility / Supplier ID**	**C**	**99**	
100.D	**REF Provider Control Number**	**C**	**99**	
110.A	**AMT Medicare Allowed Amount**	**M**	**20**	
110.B	**AMT Late Filing Reduction**	**C**	**20**	
120	**QTY -**	**N**	**0**	
130	**LQ Reference Line-level Remark Codes**	**C**	**99**	

TABLE 3

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
010	**PLB Provider-level Adjustments**	**C**	**99**	
020	**SE Transaction Set Trailer**	**M**	**1**	

TABLE 4

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
010	**GE Functional Group Trailer**	**M**	**1**	
020	**IEA Interchange Control Trailer**	**M**	**1**	

Table 2 Position 003 Note 1:
The LX segment is used to provide a looping structure and logical grouping of claim payment information.

Table 2 Position 020 Note 1:
The CAS segment is used to reflect changes to amounts within Table 2.

Table 2 Position 080 Note 1:
The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.

Table 2 Position 090 Note 1:
The CAS segment is used to reflect changes to amounts within Table 2.

Table 1 Position 040 Comment 1:
The TRN segment is used to uniquely identify a claim payment and advice.

Table 1 Position 050 Comment 1:
The CUR segment does not initiate a foreign exchange transaction.

Table 1 Position 080 Comment 1:
The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

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TABLE 0

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
010	ISA	Mandatory	Interchange Control Header	Max.	Use: 1
	ISA01	Mandatory	Authorization Information Qualifier	I01	"00"
	ISA02	Mandatory	Authorization Information	I02	AN 10 10
	ISA03	Mandatory	Security Information Qualifier	I03	"00"
	ISA04	Mandatory	Security Information	I04	AN 10 10
	ISA05	Mandatory	Interchange ID Qualifier	I05	"ZZ"
	ISA06	Mandatory	Interchange Sender ID	I06	AN 15 15
	ISA07	Mandatory	Interchange ID Qualifier	I05	"ZZ"
	ISA08	Mandatory	Transmission Receiver Identification	I07	AN 15 15
	ISA09	Mandatory	File Creation Date	I08	DT 6 6
	ISA10	Mandatory	File Creation Time	I09	TM 4 4
	ISA11	Mandatory	Interchange Control Standards Identification	I10	"U"
	ISA12	Mandatory	ANSI Version Code	I11	00305
	ISA13	Mandatory	Interchange Control Number	I12	N0 9 9
	ISA14	Mandatory	Acknowledgment Requested	I13	"0"
	ISA15	Mandatory	Test Indicator	I14	ID 1 1
	ISA16	Mandatory	Component Element Separator	I15	AN 1 1
020	GS	Mandatory	Functional Group Header	Max.	Use: 1
	GS01	Mandatory	Functional Identifier Code	0479	"HP"
	GS02	Mandatory	Carrier Identification Number	0142	AN 2 15
	GS03	Mandatory	Transmission Receiver Identification	0124	AN 2 15
	GS04	Mandatory	File Creation Date	0373	DT 6 6
	GS05	Mandatory	File Creation Time	0337	TM 4 8
	GS06	Mandatory	Group Control Number	0028	N0 1 9
	GS07	Mandatory	Responsible Agency Code	0455	"X"
	GS08	Mandatory	ANSI Version Code	0480	"003051"

TABLE 1

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
010	ST	Mandatory	Transaction Set Header	Max.	Use: 1
	ST01	Mandatory	Transaction Set Identifier Code	0143	"835"
	ST02	Mandatory	Transaction Set Control Number	0329	AN 4 9
020	BPR	Mandatory	Beginning Segment for Payment Order/	Max.	Use: 1
	BPR01	Mandatory	Transaction Handling Code	0305	ID 1 2
	BPR02	Mandatory	Provider Payment Total	0782	R 1 15
	BPR03	Mandatory	Credit/Debit Flag Code	0478	"C"
	BPR04	Mandatory	Payment Method Code	0591	ID 3 3
	BPR05	Conditional	Payment Format Code	0812	ID 1 10
	BPR06	Conditional	Carrier Bank ID Number Qualifier	0506	"01"
	BPR07	Conditional	Carrier Bank ID Number	0507	AN 3 12
	BPR08	Conditional	Carrier Account Number Qualifier	0569	"DA"
	BPR09	Conditional	Carrier Account Number	0508	AN 1 35
	BPR10	Conditional	Carrier ID Number	0509	AN 10 10
	BPR11	Not Used			
	BPR12	Conditional	Provider Bank ID Number Qualifier	0506	"01"
	BPR13	Conditional	Provider Bank ID Number	0507	AN 3 12
	BPR14	Conditional	Provider Bank Account Number Qualifier	0569	ID 1 3
	BPR15	Conditional	Provider Bank Account Number	0508	AN 1 35
	BPR16	Mandatory	Date	0373	DT 6 6
	BPR17	Not Used			
	BPR18	Not Used			
	BPR19	Not Used			
	BPR20	Not Used			
	BPR21	Not Used			
030	NTE	Not Used			
040	TRN	Mandatory	Trace	Max.	Use: 1
	TRN01	Mandatory	Trace Type Code	0481	"1"
	TRN02	Mandatory	Trace Number	0127	AN 1 30
	TRN03	Mandatory	Carrier Number	0509	AN 10 10
	TRN04	Not Used			
050	CUR	Not Used			
060.A	REF	Mandatory	Implementation GuideVersion	Max.	Use: >1
	REF01	Mandatory	Reference Number Qualifier	0128	"F5"
	REF02	Mandatory	Implementation GuideVersion	0127	“4B.00”
	REF03	Not Used			
060.B	REF	Conditional	Receiver Identification	Max.	Use: >1
	REF01	Mandatory	Reference Number Qualifier	0128	"EV"
	REF02	Mandatory	Receiver Identifier	0127	AN 1 30
	REF03	Not Used			

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
070	DTM	Mandatory	Carrier Cycle Date	Max.	Use:		>1
	DTM01	Mandatory	Date/Time Qualifier	0374	"405"		
	DTM02	Mandatory	Carrier Cycle Date	0373	DT	6	6
	DTM03	Not Used					
	DTM04	Not Used					
	DTM05	Mandatory	Century	0624	NO	2	2
	DTM06	Not Used					
	DTM07	Not Used					
			Begin Loop N1	Max.	Use:		200
080.A	N1	Mandatory	Payer Name	Max.	Use:		1
	N101	Mandatory	Entity Identifier Code	0098	"PR"		
	N102	Conditional	Payer Name	0093	AN	1	35
	N103	Conditional	Identification Code Qualifier	0066	ID	1	2
	N104	Conditional	Identification Code	0067	AN	2	20
	N105	Not Used					
	N106	Not Used					
080.B	N1	Mandatory	Payee Identification	Max.	Use:		1
	N101	Mandatory	Entity Identifier Code	0098	"PE"		
	N102	Conditional	Payee Name	0093	AN	1	35
	N103	Mandatory	Identification Code Qualifier	0066	"MP"		
	N104	Conditional	Payee ID Number	0067	AN	2	20
	N105	Not Used					
	N106	Not Used					
090	N2	Not Used					
100	N3	Not Used					
110	N4	Not Used					
120	REF	Not Used					
130	PER	Not Used					
			End Loop N1				

TABLE 2

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
			Begin Loop LX	Max.	Use: >1
003.A	LX	Conditional	Loop Indicator	Max.	Use: 1
	LX01	Mandatory	Loop Number	0554	"1"
003.B	LX	Conditional	Loop Indicator	Max.	Use: 1
	LX01	Mandatory	Loop Number	0554	"0"
005	TS3	Not Used			
007	TS2	Not Used			
			Begin Loop CLP	Max.	Use: >1
010	CLP	Mandatory	Claim Level Data	Max.	Use: 1
	CLP01	Mandatory	Patient Control Number	1028	AN 1 38
	CLP02	Mandatory	Claim Status Code	1029	ID 1 2
	CLP03	Mandatory	Claim Submitted Charge	0782	R 1 15
	CLP04	Mandatory	Claim Paid Amount	0782	R 1 15
	CLP05	Conditional	Patient Responsibility Amount	0782	R 1 15
	CLP06	Mandatory	Claim Filing Indicator Code	1032	ID 1 2
	CLP07	Mandatory	Carrier's Internal Control Number	0127	AN 1 30
	CLP08	Not Used			
	CLP09	Not Used			
	CLP10	Not Used			
	CLP11	Not Used			
	CLP12	Not Used			
	CLP13	Not Used			
020	CAS	Mandatory	Claim-Level Adjustments	Max.	Use: 99
	CAS01	Mandatory	Claim Adjustment Group Code	1033	ID 1 2
	CAS02	Mandatory	Claim Adjustment Reason Code	1034	ID 1 5
	CAS03	Mandatory	Claim Adjustment Amount	0782	R 1 15
	CAS04	Not Used			
	CAS05	Conditional	Claim Adjustment Reason Code	1034	ID 1 5
	CAS06	Conditional	Claim Adjustment Amount	0782	R 1 15
	CAS07	Not Used			
	CAS08	Conditional	Claim Adjustment Reason Code	1034	ID 1 5
	CAS09	Conditional	Claim Adjustment Amount	0782	R 1 15
	CAS10	Not Used			
	CAS11	Conditional	Claim Adjustment Reason Code	1034	ID 1 5
	CAS12	Conditional	Claim Adjustment Amount	0782	R 1 15
	CAS13	Not Used			
	CAS14	Conditional	Claim Adjustment Reason Code	1034	ID 1 5
	CAS15	Conditional	Claim Adjustment Amount	0782	R 1 15

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
	CAS16	Not Used					
	CAS17	Conditional	Claim Adjustment Reason Code	1034	ID	1	5
	CAS18	Conditional	Claim Adjustment Amount	0782	R	1	15
	CAS19	Not Used					
030.A	NM1	Mandatory	Patient Name/Number	Max.	Use:		9
	NM101	Mandatory	Patient Name/Change	0098	ID	2	2
	NM102	Mandatory	Entity Type Qualifier	1065	"1"		
	NM103	Mandatory	Patient Last Name	1035	AN	1	35
	NM104	Mandatory	Patient First Name	1036	AN	1	25
	NM105	Conditional	Patient Middle Initial	1037	AN	1	25
	NM106	Not Used					
	NM107	Not Used					
	NM108	Mandatory	HIC Number Qualifier	0066	ID	1	2
	NM109	Mandatory	HIC Number	0067	AN	2	20
030.B	NM1	Conditional	Crossed Over/Transferred	Max.	Use:		9
	NM101	Mandatory	Entity Identifier Code	0098	"TT"		
	NM102	Mandatory	Entity Type Qualifier	1065	"2"		
	NM103	Mandatory	Carrier/Supplemental Insurer Name	1035	AN	1	35
	NM104	Not Used					
	NM105	Not Used					
	NM106	Not Used					
	NM107	Not Used					
	NM108	Mandatory	Identification Code Qualifier	0066	“PI”		
	NM109	Mandatory	Identification Number	0067	AN	2	20
030.C	NM1	Conditional	Crossed Over/Transferred	Max.	Use:		9
	NM101	Mandatory	Entity Identifier Code	0098	"TT"		
	NM102	Mandatory	Entity Type Qualifier	1065	"2"		
	NM103	Mandatory	Carrier/Supplemental Insurer Name	1035	AN	1	35
	NM104	Not Used					
	NM105	Not Used					
	NM106	Not Used					
	NM107	Not Used					
	NM108	Mandatory	Identification Code Qualifier	0066	"PI"		
	NM109	Mandatory	Identification Number	0067	AN	2	20
033	MIA	Not Used					
035	MOA	Mandatory	Medicare Adjudication Remarks	Max.	Use:	1	
	MOA01	Not Used					
	MOA02	Not Used					
	MOA03	Mandatory	Remark Code	0127	AN	1	30
	MOA04	Conditional	Remark Code	0127	AN	1	30
	MOA05	Conditional	Remark Code	0127	AN	1	30
	MOA06	Conditional	Remark Code	0127	AN	1	30
	MOA07	Conditional	Remark Code	0127	AN	1	30

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
	MOA08	Not Used			
	MOA09	Not Used			
040	REF	Not Used			
050	DTM	Mandatory	Date of Receipt	Max.	Use: 9
	DTM01	Mandatory	Date/Time Qualifier	0374	"050"
	DTM02	Mandatory	Payor Receipt Date	0373	DT 6 6
	DTM03	Not Used			
	DTM04	Not Used			
	DTM05	Mandatory	Century	0624	NO 2 2
	DTM06	Not Used			
	DTM07	Not Used			
060	PER	Not Used			
062	AMT	Conditional	Monetary Amount	Max.	Use: 20
	AMT01	Mandatory	Amount Qualifier Code	0522	ID 1 2
	AMT02	Mandatory	Monetary Amount	0782	R 1 15
	AMT03	Not Used			
064	QTY	Not Used			
			Begin Loop SVC	Max.	Use: 999
070	SVC	Mandatory	Claim Service Line Data	Max.	Use: 1
	SVC01	Mandatory	Medicare Procedure Identifier	C003	Composite
	-01	Mandatory	Product/Service ID Qualifier	0235	"HC"
	-02	Mandatory	Procedure Code	0234	AN 1 40
	-03	Conditional	HCPCS Modifier	1339	AN 2 2
	-04	Conditional	HCPCS Modifier	1339	AN 2 2
	-05	Conditional	HCPCS Modifier	1339	AN 2 2
	-06	Not Used			
	-07	Not Used			
	SVC02	Mandatory	Line Submitted Charge	0782	R 1 15
	SVC03	Mandatory	Line Paid Amount	0782	R 1 15
	SVC04	Not Used			
	SVC05	Conditional	Paid Units of Service	0380	R 1 15
	SVC06	Conditional	Medicare Procedure Identifier	C003	Composite
	-01	Mandatory	Product/Service ID Qualifier	0235	"HC"
	-02	Conditional	Submitted Procedure Code	0234	AN 1 40
	-03	Not used			
	-04	Not Used			
	-05	Not Used			
	-06	Not Used			
	-07	Not Used			
	SVC07	Conditional	Submitted Units of Service	0380	R 1 15

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
080.A	DTM	Mandatory	Service Date(s)	Max.	Use:		9
	DTM01	Mandatory	Date/Time Qualifier	0374	ID	3	3
	DTM02	Mandatory	Service Date	0373	DT	6	6
	DTM03	Not Used					
	DTM04	Not Used					
	DTM05	Mandatory	Century	0624	NO	2	2
	DTM06	Not Used					
	DTM07	Not Used					
080.B	DTM	Conditional	Service Date	Max.	Use:		9
	DTM01	Mandatory	Date/Time Qualifier	0374	"151"		
	DTM02	Conditional	Service Date	0373	DT	6	6
	DTM03	Not Used					
	DTM04	Not Used					
	DTM05	Mandatory	Century	0624	NO	2	2
	DTM06	Not Used					
	DTM07	Not Used					
090	CAS	Conditional	Line-level Adjustments	Max.	Use:		99
	CAS01	Mandatory	Claim Adjustment Group Code	1033	ID	1	2
	CAS02	Mandatory	Line Adjustment Reason Code	1034	ID	1	5
	CAS03	Mandatory	Line Adjustment Amount	0782	R	1	15
	CAS04	Not Used					
	CAS05	Conditional	Line Adjustment Reason Code	1034	ID	1	5
	CAS06	Conditional	Line Adjustment Amount	0782	R	1	15
	CAS07	Not Used					
	CAS08	Conditional	Line Adjustment Reason Code	1034	ID	1	5
	CAS09	Conditional	Line Adjustment Amount	0782	R	1	15
	CAS10	Not Used					
	CAS11	Conditional	Line Adjustment Reason Code	1034	ID	1	5
	CAS12	Conditional	Line Adjustment Amount	0782	R	1	15
	CAS13	Not Used					
	CAS14	Conditional	Line Adjustment Reason Code	1034	ID	1	5
	CAS15	Conditional	Line Adjustment Amount	0782	R	1	15
	CAS16	Not Used					
	CAS17	Conditional	Line Adjustment Reason Code	1034	ID	1	5
	CAS18	Conditional	Line Adjustment Amount	0782	R	1	15
	CAS19	Not Used					
100.A	REF	Mandatory	Place of Service	Max.	Use:		99
	REF01	Mandatory	Reference Number Qualifier	0128	"LU"		
	REF02	Mandatory	Place of Service Code	0127	AN	1	30
	REF03	Not Used					

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
100.B	REF	Conditional	Performing Provider ID	Max.	Use:		99
	REF01	Mandatory	Reference Number Qualifier	0128	"1C"		
	REF02	Mandatory	Performing Provider Number	0127	AN	1	30
	REF03	Not Used					
100.C	REF	Conditional	Facility / Supplier ID	Max.	Use:		99
	REF01	Mandatory	Reference Number Qualifier	0128	"1J"		
	REF02	Mandatory	Facility ID	0127	AN	1	30
	REF03	Not Used					
100.D	REF	Conditional	Provider Control Number	Max.	Use:		99
	REF01	Mandatory	Reference Number Qualifier	0128	“6R”		
	REF02	Mandatory	Provider Control Number	0127	AN	1	30
	REF03	Not Used					
110.A	AMT	Mandatory	Medicare Allowed Amount	Max.	Use:		20
	AMT01	Mandatory	Amount Qualifier Code	0522	"B6"		
	AMT02	Mandatory	Medicare Allowed Amount	0782	R	1	15
	AMT03	Not Used					
110.B	AMT	Conditional	Late Filing Reduction	Max.	Use:		20
	AMT01	Mandatory	Amount Qualifier Code	0522	"KH"		
	AMT02	Mandatory	Late Filing Reduction	0782	R	1	15
	AMT03	Not Used					
120	QTY	Not Used					
130	LQ	Conditional	Reference Line-level Remark Codes	Max.	Use:		99
	LQ01	Mandatory	Code List Qualifier Code	1270	“HE”		
	LQ02	Mandatory	Reference-Line Remark Codes	1271	AN	1	30
			End Loop SVC				
			End Loop CLP				
			End Loop LX				

TABLE 3

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
010	PLB	Conditional	Provider-level Adjustments	Max.	Use:		99
	PLB01	Mandatory	Provider Number	0127	AN	1	30
	PLB02	Mandatory	End of Calendar Year	0373	DT	6	6
	PLB03	Mandatory	Provider Adjustment Reason Code	0127	AN	1	30
	PLB04	Mandatory	Provider Adjustment Amount	0782	R	1	15
	PLB05	Conditional	Provider Adjustment Reason Code	0127	AN	1	30
	PLB06	Conditional	Provider Adjustment Amount	0782	R	1	15
	PLB07	Conditional	Provider Adjustment Reason Code	0127	AN	1	30
	PLB08	Conditional	Provider Adjustment Amount	0782	R	1	15
	PLB09	Conditional	Provider Adjustment Reason Code	0127	AN	1	30
	PLB10	Conditional	Provider Adjustment Amount	0782	R	1	15
	PLB11	Conditional	Provider Adjustment Reason Code	0127	AN	1	30
	PLB12	Conditional	Provider Adjustment Amount	0782	R	1	15
	PLB13	Conditional	Provider Adjustment Reason Code	0127	AN	1	30
	PLB14	Conditional	Provider Adjustment Amount	0782	R	1	15
020	SE	Mandatory	Transaction Set Trailer	Max.	Use:		1
	SE01	Mandatory	Transaction Segment Count	0096	N0	1	10
	SE02	Mandatory	Transaction Set Control Number	0329	AN	4	9

TABLE 4

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes		
010	GE	Mandatory	Functional Group Trailer	Max.	Use:		1
	GE01	Mandatory	Group Set Count	0097	N0	1	6
	GE02	Mandatory	Group Control Number	0028	N0	1	9
020	IEA	Mandatory	Interchange Control Trailer	Max.	Use:	1	
	IEA01	Mandatory	Transmission Group Count	I16	N0	1	5
	IEA02	Mandatory	Interchange Control Number	I12	N0	9	9

END OF TABLES

X12 Segment Name: **ISA Interchange Control Header**
Loop: ----
Max. Use: 1
X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments.
Usage: **Mandatory**
Example: ISA*00*.....*00*.....*ZZ*9000000553.....*
ZZ*MEDSERVER.....*970505*0436*U*00305*125000102*0*P*>~
Comments: The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire exchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire exchange. The blank spaces in the example have been replaced by periods for clarity. If no meaningful data is available for an element, you must fill it with the requisite number of blanks.

Element Attributes	Data Element Usage	NSF Mapping
ISA01 I01 ID 2 2 M	Authorization Information Qualifier Code to identify the type of information in the Authorization Information. Codes: **00 No Authorization Information Present (No Meaningful Information in I02)**	**Translator Generated (TG)**
ISA02 I02 AN 10 10 M	Authorization Information Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01) **Enter ten spaces.**	**TG**
ISA03 I03 ID 2 2 M	Security Information Qualifier Code to identify the type of information in the Security Information. Codes: **00 No Security Information Present (No Meaningful Information in I04)**	**TG**
ISA04 I04 AN 10 10 M	Security Information This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03) **Enter ten spaces.**	**TG**

ISA05 ID 2 2 M	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: **ZZ Mutually Defined**	**TG**
ISA06 I06 AN 15 15 M	Interchange Sender ID Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. **When going through a Value Added Network (VAN), this number will be the VAN ID as mutually defined or as issued by the VAN. When not going through a VAN, use the HCFA-assigned carrier number. The HCFA carrier-assigned number will be the default value.**	**TG**
ISA07 I05 ID 2 2 M	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: **ZZ Mutually Defined**	**TG**
ISA08 I07 AN 15 15 M	Interchange Receiver ID **Transmission Receiver Identification Number** Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. **This would be one of the following numbers as agreed to by the carrier and the trading partner:** **1) VAN ID** **2) EDI Submitter ID** **3) Provider Chain ID** **4) Provider ID/NPI**	**TG**

ISA09 I08 DT 6 6 M	Interchange Date **File Creation Date** Date of the interchange. **Format YYMMDD.**	**TG**
ISA10 I09 TM 4 4 M	Interchange Time **File Creation Time** Time of the interchange. **Format HHMM.**	**TG**
ISA11 I10 ID 1 1 M	Interchange Control Standards Identifier Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer. Codes: **U--U.S. EDI Community of ASC X12, TDCC, and UCS**	**TG**
ISA12 I11 ID 5 5 M	Interchange Control Version Number **ANSI Version Code** This version number covers the interchange control segments. **For Version 3051, enter "00305" in this field.**	**TG**
ISA13 I12 N0 9 9 M	Interchange Control Number A control number assigned by the interchange sender. **The Interchange Control Number, ISA13, must be identical to the one found in the associated Interchange Trailer IEA02. Cannot be left blank.**	**TG**
ISA14 I13 ID 1 1 M	Acknowledgment Requested Code sent by the sender to request an interchange acknowledgment (TA1) **Medicare does not require providers to send functional acknowledgements.** Codes: **0 No Acknowledgment Requested**	**TG**

ISA15 I14 ID 1 1 M	Test Indicator Code to indicate whether data enclosed by this interchange envelope is test or production. Codes: **P Production Data** **T Test Data**	**TG**
ISA16 I15 AN 1 1 M	Component Element Separator This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator. **Cannot be left blank. ">" is recommended.**	**TG**

X12 Segment Name: **GS Functional Group Header**
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the beginning of a functional group and to provide control information.
Usage: **Mandatory**
Example: GS*HP*03330*MEDEX*970218*153206*1*X*003051~
Comments: All fields must contain data. Write only one GS segment per functional group. A new functional group will be created if the data in any GS element changes.

Semantic Note: GS04 is the Group Date.
Semantic Note: GS05 is the Group Time.
Semantic Note: The data interchange control number GS06 in this header must be identical to the same data element in the associated Functional Group Trailer GE02.

X12 Comment: A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Element Attributes	Data Element Usage	NSF Mapping
GS01 0479 ID 2 2 M	Functional Identifier Code Code identifying a group of application related Transaction Sets. Codes: **HP Health Care Claim Payment/ Advice (835)**	**TG**
GS02 0142 AN 2 15 M	Application Sender's Code **Carrier Identification Number** Code identifying party sending transmission. Codes agreed to by trading partners.	**100-02**
GS03 0124 AN 2 15 M	Application Receiver's Code **Transmission Receiver Identification Number** Code identifying party receiving transmission. Codes agreed to by trading partners. This could be the same as or different than ISA08.	**TG**

GS04 0373 DT 6 6 M	Date **File Creation Date** Date (YYMMDD).	**TG**
GS05 0337 TM 4 8 M	Time **File Creation Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **Use a minimum of four zeros if there is no significant data for this field.**	**TG**
GS06 0028 N0 1 9 M	Group Control Number Assigned number originated and maintained by the sender. **The group control number, GS06, must be identical to the one found in the associated function trailer GE02.**	**TG**
GS07 0455 ID 1 2 M	Responsible Agency Code Code used in conjunction with Data Element 480 to identify the issuer of the standard. Codes: **X Accredited Standards Committee X12**	**TG**
GS08 0480 AN 1 12 M	Version / Release / Industry Identifier Code **ANSI Version Code** Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments. If code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers	**TG**

(optionally assigned by user). If code in DE455 in GS segment is T, then other formats are allowed.

The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version

Codes:

003051 -- Draft Standards Approved for Publication by ASC X12 Procedures Review Board through February 1995

X12 Segment Name: **ST Transaction Set Header**
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the start of a transaction set and to assign a control number.
Usage: **Mandatory**
Example: ST*835*0019~
Comments: Write one ST segment for each transaction set.

Semantic Note:	The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the invoice transaction set).

Element Attributes	Data Element Usage	NSF Mapping
ST01 0143 ID 3 3 M	Transaction Set Identifier Code Code uniquely identifying a Transaction Set. Codes: **835-- X12.85 Health Care Claim Payment/Advice**	**TG**
ST02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The transaction set control number, ST02, must be identical to the same data element in the associated transaction set trailer, SE02. This can be the remittance advice sequence number.**	**200-05, 800-05 (or translator generated)**

X12 Segment Name: **BPR Beginning Segment for Payment Order/Remittance Advice**
Loop: ----
Max. Use: 1
X12 Purpose: (1) To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount or (2) to enable related transfer of funds and/or information from payer to payee to occur
Purpose: **This segment contains the payment amount for a particular billing provider.**
Usage: **Mandatory**
Example: BPR*I*500*C*CHK**********970524~
Comments: Write one BPR segment for each provider or chain entity. BPR05 through BPR15 are only applicable when an EFT or remittance information is being sent through a financial institution.

Syntax Note: P0607 - If either BPR06 or BPR07 is present, then the other must be present.
Syntax Note: C0809 - If BPR08 is present, then BPR09 must be present.
Syntax Note: P1213 - If either BPR12 or BPR13 is present, then the other must be present.
Syntax Note: C1415 - If BPR14 is present, then BPR15 must be present.
Syntax Note: P1819 - If either BPR18 or BPR19 is present, then the other must be present.
Syntax Note: C2021 - If BPR20 is present, then BPR21 must be present.

Semantic Note: BPR02 specifies the payment amount.
Semantic Note: When using this transaction set to initiate a payment, BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.
Semantic Note: BPR06 and BPR07 relate to the originating depository financial institution (ODFI).
Semantic Note: BPR08 is a code identifying the type of bank account or other financial asset.
Semantic Note: BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).
Semantic Note: BPR14 is a code identifying the type of bank account or other financial asset.
Semantic Note: BPR15 is the account number of the receiving company to be debited or credited with the payment order.
Semantic Note: BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).
Semantic Note: BPR17 is a code identifying the business reason for the this payment.
Semantic Note: BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.
Semantic Note: BPR20 is a code identifying the type of bank account or other financial asset.

X12 Comment: BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.

Element Attributes	Data Element Usage	NSF Mapping
BPR01 0305 ID 1 2 M	Transaction Handling Code **Data Indicator** Code designating the action to be taken by all parties. **Use code "D" for abbreviated 835 only. Use "H" when no payments made or all claims are unassigned. Use code "P" if a bank requires that a prenote be sent.**	**200-15**

	Codes: **C Payment Accompanies Remittance Advice** **D Make Payment Only** **I Remittance Information Only** **H Notification Only** **P Prenotification of Future Transfers**	
BPR02 0782 R 1 15 M	Monetary Amount **Provider Payment Total** Monetary amount. **This is the total actual check or EFT payment to the billing provider. This value cannot be less than zero.**	**800-22**
BPR03 0478 ID 1 1 M	Credit/Debit Flag Code Code indicating whether amount is a credit or debit. Codes: **C Credit**	**TG**
BPR04 0591 ID 3 3 M	Payment Method Code Code identifying the method for the movement of payment instructions **If BPR04 is ACH, then BPR05 through BPR15 must be present, except BPR11.** Codes: **ACH Automated Clearing House (ACH)** **BOP Financial Institution Option** **CHK Check** **NON Non-Payment Data**	**200-16**
BPR05 0812 ID 1 10 C	Payment Format Code Code identifying the payment format to be used. **CCD is not recommended.** Codes: **CCD Cash Concentration/Disbursement (CCD) (ACH)** **CTX Corporate Trade Exchange (CTX) (ACH)** **CCP Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)**	**200-17**

BPR06 0506 ID 2 2 C	(DFI) ID Number Qualifier **Carrier Bank ID Number Qualifier** Code identifying the type of identification number of Depository Financial Institution (DFI). Codes: **01 ABA Transit Routing Number Including Check Digits (9 digits)**	**TG**
BPR07 0507 AN 3 12 C	(DFI) Identification Number **Carrier Bank ID Number** Depository Financial Institution (DFI) identification number. **Must be obtained from the carrier's files.**	**TG**
BPR08 0569 ID 1 3 C	Account Number Qualifier **Carrier Account Number Qualifier** Code indicating the type of account. Codes: **DA Demand Deposit**	**TG**
BPR09 0508 AN 1 35 C	Account Number **Carrier Account Number** Account number assigned. **Must be obtained from the carrier's files.**	**200-14**
BPR10 0509 AN 10 10 C	Originating Company Identifier **Carrier ID Number** A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number. The ICD for an EIN is 1, DUNS is 3, user assigned number is 9. **BPR10 is mandatory when the 835 is sent to a bank. Must be coordinated with the carrier's bank. Space fill the Carrier**	**100-02, 100-05, 200-02 400-02, 450-02, 451-02 500-02, 700-02, 800-02 900-02, 900-05**

	ID field to the right for a total of ten positions when the Carrier ID is less than 10 positions in length.	
BPR11 0510	Originating Company Supplemental Code **Not Used.**	
BPR12 0506 ID 2 2 C	(DFI) ID Number Qualifier **Provider Bank ID Number Qualifier** Code identifying the type of identification number of Depository Financial Institution (DFI). Codes: **01 ABA Transit Routing Number Including Check Digits (9 digits)**	**TG**
BPR13 0507 AN 3 12 C	(DFI) Identification Number **Provider Bank ID Number** Depository Financial Institution (DFI) identification number. **Note: Use for abbreviated 835 or when sending dollars and remittance through the bank.**	**200-11**
BPR14 0569 ID 1 3 C	Account Number Qualifier **Provider Bank Account Number Qualifier** Code indicating the type of account. Codes: **DA Demand Deposit** **SG Savings**	**200-18**
BPR15 0508 AN 1 35 C	Account Number **Provider Bank Account Number** Account number assigned.	**200-12**
BPR16 0373 DT 6 6 M	Date Date (YYMMDD). **This element identifies the effective entry date for payment, i.e., the date the EFT funds are available to the provider, check issue date, or statement issue date.**	**200-09**

BPR17 1048 Business Function Code
Not Used.

BPR18 0506 (DFI) ID Number Qualifier
Not Used.

BPR19 0507 (DFI) Identification Number
Not Used.

BPR20 0569 Account Number Qualifier
Not Used.

BPR21 0508 Account Number
Not Used.

X12 Segment Name: **TRN Trace**
Loop: ----
Max. Use: 1
X12 Purpose: To uniquely identify a transaction to an application.
Purpose: **This payor-defined trace number permits a provider to associate the electronic remittance notice with an electronic funds transfer, paper check, or paper non-payment voucher.**
Usage: **Mandatory**
Example: TRN*1*8765320*9000000770~

Semantic Note: TRN02 provides unique identification for the transaction.
Semantic Note: TRN03 identifies an organization.
Semantic Note: TRN04 identifies a further subdivision within the organization.

Element Attributes	Data Element Usage	NSF Mapping
TRN01 0481 ID 1 2 M	Trace Type Code Code identifying which transaction is being referenced. Codes: **1 Current Transaction Trace Numbers**	**TG**
TRN02 0127 AN 1 30 M	Reference Number **Trace Number** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **Contains either the unique trace number from an EFT, the unique MICR check number from a paper check, or the voucher number from a non-payment paper remittance.**	**200-08**
TRN03 0509 AN 10 10 M	Originating Company Identifier **Carrier Number** A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering	**100-02, 100-05, 200-02** **400-02, 450-02, 451-02** **500-02, 700-02, 800-02** **900-02, 900-05**

	system (DUNS), or a user assigned number. The ICD for an EIN is 1, DUNS is 3, user assigned number is 9. **This will be the Medicare-assigned carrier number.**
TRN04 0127	Reference Number **Not Used.**

X12 Segment Name: **REF Reference Numbers**
Name: **Implementation Guide Version**
Loop: ----
Max. Use: >1
X12 Purpose: To specify identifying numbers.
Purpose: **To convey the implementation guide version for this transaction.**
Usage: **Mandatory**
Example: REF*F5*4B.00~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **F5 -- Medicare Version Code Identifies the release of a set of Medicare system requirements to distinguish from previous or future sets that may differ.**	**TG**
REF02 0127 AN 1 30 M	Reference Number **Implementation Guide Version** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **This code identifies the implementation guide version for this transaction.** **Codes:** **4B.00 -- Implementation Guide version code as used for this transaction.**	**TG**
REF03 0352	Description **Not Used.**	

X12 Segment Name: **REF Reference Numbers**
Name: **Receiver Identification**
Loop: ----
Max. Use: >1
X12 Purpose: To specify identifying numbers.
Purpose: To convey the ID number of the receiver of this remittance advice.
Usage: **Conditional**
Example: REF*EV*MEDEX~
Comments: This segment is required if the receiver ID is not equal to the provider ID.

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **EV -- Receiver Identification Number** **A unique number identifying the organization/site location designated to receive the current transmitted transaction set**	
REF02 0127 AN 1 30 M	Reference Number **Receiver Identifier** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **This code conveys the receiver's identification code as assigned by the payor. It identifies the recipient of the entire file and is identical to the transmission receiver identification number in ISA08.**	**100-03, 900-03**
REF03 0352	Description **Not Used.**	

X12 Segment Name: **DTM Date/Time Reference**
Name: **Carrier Cycle Date**
Loop: ----
Max. Use: >1
X12 Purpose: To specify pertinent dates and times.
Purpose: To identify the payor's processing cycle which created this remittance.
Usage: **Mandatory**
Example: DTM*405*970217***19~
Comments: This segment is mandatory for Medicare. This segment appears only once.

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.
Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element Attributes	Data Element Usage	NSF Mapping
DTM01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes: **405 Production**	**TG**
DTM02 0373 DT 6 6 M	Date **Carrier Cycle Date** Date (YYMMDD). **The date which identifies the payor's processing cycle which created this remittance.**	**200-10**
DTM03 0337	Time **Not Used.**	
DTM04 0623	Time Code **Not Used.**	
DTM05 0624 NO 2 2 M	Century The first two characters in the designation of the year (CCYY).	**200-10** **(first 2 digits)**
DTM06 1250	Date Time Period Format Qualifier **Not Used.**	

DTM07 1251	Date Time Period **Not Used.**

X12 Segment Name: **N1 Name**
Name: **Payer Name**
Loop: N1
Max. Use: 1
X12 Purpose: To identify a party by type of organization, name and code.
Purpose: **To identify the payer of this remittance.**
Usage: **Mandatory**
Example: N1*PR*SOMEWHERE INSURANCE COMPANY*****~

Syntax Note: R0203 - At least one of N102 or N103 must be present.
Syntax Note: P0304 - If either N103 or N104 is present, then the other must be present.

X12 Comment: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
X12 Comment: N105 and N106 further define the type of entity in N101.

Element Attributes	Data Element Usage	NSF Mapping
N101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual. Codes: **PR Payer**	**TG**
N102 0093 AN 1 35 C	Name **Payer Name** Free-form name. **The carrier's company name.**	**TG**
N103 0066 ID 1 2 C	Identification Code Qualifier **Qualifier for the National PAYERID of the payer (when effective).** **ZZ Mutually Defined**	**TG**
N104 0067 AN 2 20 C	Identification Code **National PAYERID number (when effective).**	**100-02**
N105 0706	Entity Relationship Code **Not Used.**	
N106 0098	Entity Identifier Code **Not Used.**	

X12 Segment Name: **N1 Name**
Name: **Payee Identification**
Loop: N1
Max. Use: 1
X12 Purpose: To identify a party by type of organization, name and code.
Purpose: **To identify the payee or recipient of this remittance.**
Usage: **Mandatory**
Example: N1*PE*PROFESSIONAL ASSOCIATION*MP*123456~

Syntax Note: R0203 - At least one of N102 or N103 must be present.
Syntax Note: P0304 - If either N103 or N104 is present, then the other must be present.

X12 Comment: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
X12 Comment: N105 and N106 further define the type of entity in N101.

Element Attributes	Data Element Usage	NSF Mapping
N101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual. Codes: **PE Payee**	**TG**
N102 0093 AN 1 35 C	Name **Payee Name** Free-form name. **The name of the payee or recipient of this remittance.**	**200-06**
N103 0066 ID 1 2 M	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: **MP -- Medicare Provider Number** **Number assigned to a health care provider for submitting claims covered by Medicare benefits.**	**TG**

N104 0067 AN 2 20 M	Identification Code **Payee ID Number** Code identifying a party or other code. **The Medicare number of the payee. The National Provider Identifier (NPI) must be entered here when effective.**	**200-07**
N105 0706	Entity Relationship Code **Not Used.**	
N106 0098	Entity Identifier Code **Not Used.**	

X12 Segment Name: **LX Assigned Number**
Name: **Loop Indicator**
Loop: LX
Max. Use: 1
X12 Purpose: To reference a line number in a transaction set.
Purpose: **To alert the receiver's translator program that a loop or series of segments follows that carry claim information.**
Usage: **Conditional**
Example: LX*1~
Comments: This segment is mandatory for Medicare if the provider accepted assignment except for the abbreviated 835.

Element Attributes	Data Element Usage	NSF Mapping
LX01 0554 N0 1 6 M	Assigned Number **Loop Number** Number assigned for differentiation within a transaction set. Use a constant "1" for assigned.	**200-19**

X12 Segment Name: **LX Assigned Number**
Name: **Loop Indicator**
Loop: LX
Max. Use: 1
X12 Purpose: To reference a line number in a transaction set.
Purpose: **To alert the receiver's translator program that a loop or series of segments follows that carry claim information.**
Usage: **Conditional**
Example: LX*0~
Comments: This segment is mandatory for Medicare if the provider did not accept assignment except for the abbreviated 835.

Element Attributes	Data Element Usage	NSF Mapping
LX01 0554 N0 1 6 M	Assigned Number **Loop Number** Number assigned for differentiation within a transaction set. Use a constant "0" for unassigned claims.	**200-19**

X12 Segment Name: **CLP Claim Level Data**
Loop: CLP Repeat >1
Max. Use: 1
X12 Purpose: To supply information common to all services of a claim
Usage: **Mandatory**
Example: CLP*76543SMITH*1*500*200*100*MB*9702M1234567~
Comments: This is the first segment written for each claim.

Semantic Note: CLP03 is the amount of submitted charges this claim.
Semantic Note: CLP04 is the amount paid this claim.
Semantic Note: CLP05 is the patient responsibility amount.
Semantic Note: CLP07 is the payer's internal control number.
Semantic Note: CLP12 is the diagnosis-related group (DRG) weight.

Element Attributes	Data Element Usage	NSF Mapping
CLP01 1028 AN 1 38 M	Claim Submitter's Identifier **Patient Control Number** Identifier used to track a claim from creation by the health care provider through payment. **Claim identifier originally assigned by the provider. It is carried through the payor's system and returned to the provider to allow account posting. If the Patient Control Number is not present on the incoming claim, enter a zero in this element.**	**400-03, 450-03, 451-03, 500-03**
CLP02 1029 ID 1 2 M	Claim Status Code Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization. **Codes 5, 10, 13, 15, 16, 17 are optional.** Codes:	**400-18, 400-19**
	1 Processed as Primary	**70 Complete, Paid,400-18=N**
	2 Processed as Secondary	**71 Complete, Paid,400-18=N**
	3 Processed as Tertiary	**72 Complete, Paid,400-18=N**
	4 Denied	**80/90 Complete, No Pay/Rejected**
	5 Pended	**20 Development**
	10 Received, but not in process	**00 Controlled Only**
	13 Suspended	**10 In Process**
	15 Suspended - investigation with field	**40 Services Review**

	16 Suspended - return with material **17 Suspended - review pending** **19 Processed as Primary and Crossed Over** **20 Processed as Secondary and Crossed Over** **21 Processed as Tertiary and Crossed Over** **22 Reversal of Previous Payment** **23 Not Our Claim and Crossed Over** **27 Reviewed**	**60 Reply Resolution** **30 Medical & Utilization** **70 Complete, Paid,400-18=Y** **71 Complete, Paid,400-18=Y** **72 Complete, Paid,400-18=Y** **01 Reversal, Previous Payment** **05 Claim transferred** **02 Returned, Unprocessable**
CLP03 0782 R 1 15 M	Monetary Amount **Claim Submitted Charge** Monetary amount. **The total submitted charges for this claim.**	**500-05**
CLP04 0782 R 1 15 M	Monetary Amount **Claim Paid Amount** Monetary amount. **The payment to the provider for this claim, not including interest and any late filing charges. This amount can be less than zero.**	**500-15**
CLP05 0782 R 1 15 C	Monetary Amount **Patient Responsibility Amount** Monetary amount. **The amount of patient liability for this claim under Medicare regulations. It must be provided if greater than zero.**	**500-23**
CLP06 1032 ID 1 2 M	Claim Filing Indicator Code **MB Medicare Part B**	**TG**
CLP07 0127 AN 1 30 M	Reference Number **Carrier's Internal Control Number** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **The carrier-assigned identifier for this claim.**	**400-22, 450-45, 451-06, 500-21**

CLP08 1331 Facility Code Value
Not Used.

CLP09 1325 Claim Frequency Type Code
Not Used.

CLP10 1352 Patient Status Code
Not Used.

CLP11 1354 Diagnosis Related Group (DRG) Code
Not Used.

CLP12 0380 Quantity
Not Used.

CLP13 0954 Percent
Not Used.

X12 Segment Name: **CAS Claims Adjustment**
Name: **Claim-Level Adjustments**
Loop: CLP
Max. Use: 99
X12 Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.
Purpose: **To supply claim-level adjustment reasons and amounts for payment adjustments. Do not report interest amounts in this segment. Use the claim level AMT segment for reporting interest paid on a claim. (Service-level adjustments are reported in 2-090-CAS and provider -level adjustments are reported in 3-010-PLB.)**
Usage: **Mandatory**
Example: CAS*OA*93*0~
Comments: ***1. Claim-level payment adjustments are indicated in this segment. Adjustments should be entered in the sequence they are applied by the payor's system.
***2. Each claim adjustment amount relates to the immediately preceding adjustment reason code.
***3. Use the applicable reason code described in the ANSI ASC X12 reason code list (appendix C).
***4. Positive adjustments decrease payment and negative adjustments increase payment.
***5. At least one group and reason code is required at the claim level. If no claim level adjustment exists, write group code "OA" in CAS01, reason code "93" in CAS02, and a claim adjustment amount of "0" (zero) in CAS03.
***6. If CAS03 is mapped to a NSF field where the name of that NSF field supplies the reason, do not map CAS02. Hard Code the appropriate code (see Appendix B for further explanation).

Syntax Note: L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 must be present.
Syntax Note: C0605 - If CAS06 is present, then CAS05 must be present.
Syntax Note: C0705 - If CAS07 is present, then CAS05 must be present.
Syntax Note: L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 must be present.
Syntax Note: C0908 - If CAS09 is present, then CAS08 must be present.
Syntax Note: C1008 - If CAS10 is present, then CAS08 must be present.
Syntax Note: L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 must be present.
Syntax Note: C1211 - If CAS12 is present, then CAS11 must be present.
Syntax Note: C1311 - If CAS13 is present, then CAS11 must be present.
Syntax Note: L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 must be present.
Syntax Note: C1514 - If CAS15 is present, then CAS14 must be present.
Syntax Note: C1614 - If CAS16 is present, then CAS14 must be present.
Syntax Note: L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 must be present.
Syntax Note: C1817 - If CAS18 is present, then CAS17 must be present.
Syntax Note: C1917 - If CAS19 is present, then CAS17 must be present.

Semantic Note: CAS03 is the amount of adjustment.
Semantic Note: CAS04 is the units of service being adjusted.
Semantic Note: CAS06 is the amount of the adjustment.
Semantic Note: CAS07 is the units of service being adjusted.
Semantic Note: CAS09 is the amount of the adjustment.
Semantic Note: CAS10 is the units of service being adjusted.
Semantic Note: CAS12 is the amount of the adjustment.
Semantic Note: CAS13 is the units of service being adjusted.
Semantic Note: CAS15 is the amount of the adjustment.
Semantic Note: CAS16 is the units of service being adjusted.
Semantic Note: CAS18 is the amount of the adjustment.
Semantic Note: CAS19 is the units of service being adjusted.

X12 Comment: Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

X12 Comment: When the submitted charges are paid in full, the value for CAS03 should be zero.

Element Attributes	Data Element Usage	NSF Mapping
CAS01 1033 ID 1 2 M	Claim Adjustment Group Code Code identifying the general category of payment adjustment. Codes: **CO Contractual Obligation** - Payment adjustment where the provider did not meet a payer-determined program requirement and is always financially liable. **CR Correction** - Change to a previously processed claim. This does not express liability. **OA Other Adjustment** - Any other adjustment. Do not include any adjustment for which the patient or provider has financial liability. **PR Patient Responsibility Adjustment** - Any adjustment where the patient has assumed or will be assuming financial responsibility.	**500-30 to 32 (first 2 spaces) or TG:** **CO - 500-12** **OA - 500-13, 500-17**
CAS02 1034 ID 1 5 M	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment is being made. **See codes in Appendix C.**	**500-30 to 32 (spaces 3 - 6) or TG for: 500-09, 500-10, 500-12, 500-13**
CAS03 0782 R 1 15 M	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**500-12 (CO), 500-17 (OA) 500-13 (OA), 500-33 to 35**
CAS04 0380	Quantity **Not Used.**	

CAS05 1034 ID 1 5 C	Claim Adjustment Reason Code Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS06 0782 R 1 15 C	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**See CAS 03**
CAS07 0380	Quantity **Not Used.**	
CAS08 1034 ID 1 5 C	Claim Adjustment Reason Code Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS09 0782 R 1 15 C	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**See CAS 03**
CAS10 0380	Quantity **Not Used.**	
CAS11 1034 ID 1 5 C	Claim Adjustment Reason Code Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS12 0782 R 1 15 C	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**See CAS 03**
CAS13 0380	Quantity **Not Used.**	
CAS14 1034 ID 1 5 C	Claim Adjustment Reason Code Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**

CAS15 0782 R 1 15 C	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**See CAS 03**
CAS16 0380	Quantity **Not Used.**	
CAS17 1034 ID 1 5 C	Claim Adjustment Reason Code Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS18 0782 R 1 15 C	Monetary Amount **Claim Adjustment Amount** Monetary amount.	**See CAS 03**
CAS19 0380	Quantity **Not Used.**	

X12 Segment Name: **NM1 Individual or Organizational Name**
Name: **Patient Name/Number**
Loop: CLP
Max. Use: 9
X12 Purpose: To supply the full name of an individual or organizational entity.
Purpose: **To identify the patient for whom this claim was submitted. Write one segment for each claim.**
Usage: **Mandatory**
Example: NM1*QC*1*SMITH*JOHN****HN*321459876~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	NSF Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code **Patient Name/Change** Code identifying an organizational entity, a physical location, or an individual Codes: **QC Patient Name** **Individual receiving medical care** **74 Corrected Patient Name**	 **QC = TG** **74 = 400-28**
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: **1 Person**	**TG**
NM103 1035 AN 1 35 M	Name Last or Organization Name **Patient Last Name** Individual last name or organizational name.	**400-13**
NM104 1036 AN 1 25 M	Name First **Patient First Name** Individual first name.	**400-14**
NM105 1037 AN 1 25 C	Name Middle **Patient Middle Initial** Individual middle name or initial.	**400-15**

NM106 1038	Name Prefix **Not Used.**		
NM107 1039	Name Suffix **Not Used.**		
NM108 0066 ID 1 2 M	Identification Code Qualifier **HIC Number Qualifier** Code designating the system/method of code structure used for Identification Code (67). Codes:		
	C	**Insured's Changed Unique Identification Number**	**C = 400-08**
	HN	**Health Insurance Claim (HIC) Number** **Unique number assigned to Individual for submitting claims covered by Medicare benefits.**	**HN = TG**
NM109 0067 AN 2 20 M	Identification Code **HIC Number** **Code identifying a party or other code.** **The patient's Health Insurance Claim Number.**		**400-07**

X12 Segment Name: **NM1 Individual or Organizational Name**
Name: **Crossed Over/Transferred**
Loop: CLP
Max. Use: 9
X12 Purpose: To supply the full name of an individual or organizational entity.
Purpose: **To identify the organization name to whom this claim was forwarded.**
Usage: **Conditional**
Example: NM1*TT*2*SOMEWHERE INSURANCE CO*****PI*123456~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	NSF Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual. **For Medicare, "TT" identifies the other carrier or supplemental insurer to whom the claim was forwarded.** Codes: **TT Transfer To**	**TG**
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: **2 Non-Person Entity**	**TG**
NM103 1035 AN 1 35 M	Name Last or Organization Name **Carrier/Supplemental Insurer Name** Individual last name or organizational name.	**500-25**
NM104 1036	Name First **Not Used**.	
NM105 1037	Name Middle **Not Used.**	
NM**1**06 1038	Name Prefix **Not Used.**	

NM107 1039	Name Suffix **Not Used.**	
NM108 0066 ID 1 2 M	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: **PI Payor Identification**	**TG**
NM109 0067 AN 2 20 M	Identification Code **Identification Number** Code identifying a party or other code. **The field should contain a unique number that identifies the organization in NM103. The PAYERID must be entered here when effective.**	**500-26**

X12 Segment Name: **NM1 Individual or Organizational Name**
Name: **Crossed Over/Transferred**
Loop: CLP
Max. Use: 9
X12 Purpose: To supply the full name of an individual or organizational entity.
Purpose: **To identify the organization name to whom this claim was forwarded if there is more than one supplemental insurer.**
Usage: **Conditional**
Example: NM1*TT*2*SOMEWHERE INSURANCE CO*****PI*123456~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	NSF Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual. **For Medicare, "TT" identifies the other carrier or supplemental insurer to whom the claim was forwarded.** Codes: **TT Transfer To**	**TG**
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: **2 Non-Person Entity**	**TG**
NM103 1035 AN 1 35 M	Name Last or Organization Name **Carrier/Supplemental Insurer Name** Individual last name or organizational name	**500-27**
NM104 1036	Name First **Not Used.**	
NM105 1037	Name Middle **Not Used.**	

NM106 1038	Name Prefix **Not Used.**	
NM107 1039	Name Suffix **Not Used.**	
NM108 0066 ID 1 2 M	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: **PI Payor Identification**	**TG**
NM109 0067 AN 2 20 M	Identification Code **Identification Number** Code identifying a party or other code. **The field should contain a unique number that identifies the organization in NM103. The PAYERID must be entered here when effective.**	**500-28**

X12 Segment Name: **MOA Medicare Outpatient Adjudication**
Name: Medicare Adjudication Remarks
Loop: CLP
Max. Use: 1
X12 Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting.
Purpose: **To convey claim-level remarks related to the adjudication of Medicare Part B claims. These remarks do not describe money amount, quantity, or value (please refer to 2-020-CAS segment for payment adjustments) at the claim level.**
Usage: **Conditional**
Example: MOA**MA01*MA10*MA61~
Comments: The MOA segment must beused when there are remarks related to Medicare notifications or carrier instructions. Use the standardized Medicare message codes for acceptable MOA codes. An appeal message must always be used at a minimum when there has been a denial or reduction from the billed amount.

Semantic Note:	MOA01is the reimbursement rate.
Semantic Note:	MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
Semantic Note:	MOA03 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
Semantic Note:	MOA04 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
Semantic Note:	MOA05 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
Semantic Note:	MOA06 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
Semantic Note:	MOA07 is the Health Care Financing Administration Payment Remark code. See Source 411.
Semantic Note:	MOA08 is the End Stage Renal Disease (ESRD) payment amount.
Semantic Note:	MOA09 is the professional component amount billed but not payable.

Element Attributes	Data Element Usage	NSF Mapping
MOA01 0954	Percent **Not Used.**	
MOA02 0782	Monetary Amount **Not Used.**	
MOA03 0127 AN 1 30 C	Reference Number **Remark Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	**400-23**

	Medicare remark code pertaining to this claim. Use standard code list (appendix C).	
MOA04 0127 AN 1 30 C	Reference Number **Remark Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **Medicare remark code pertaining to this claim. Use standard code list (appendix C).**	**400-24**
MOA05 0127 AN 1 30 C	Reference Number **Remark Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **Medicare remark code pertaining to this claim. Use standard code list (appendix C).**	**400-25**
MOA06 0127 AN 1 30 C	Reference Number **Remark Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **Medicare remark code pertaining to this claim. Use standard code list (appendix C).**	**400-26**
MOA07 0127 AN 1 30 C	Reference Number **Remark Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **Medicare remark code pertaining to this claim. Use standard code list (appendix C).**	**400-27**

MOA08 0782 Monetary Amount
Not Used.

MOA09 0782 Monetary Amount
Not Used.

X12 Segment Name: **DTM Date/Time Reference**
Name: **Date of Receipt**
Loop: CLP
Max. Use: 9
X12 Purpose: To specify pertinent dates and times.
Usage: **Mandatory**
Example: DTM*050*970128***19~

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.
Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element Attributes	Data Element Usage	NSF Mapping
DTM01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes: **050 Received**	**TG**
DTM02 0373 DT 6 6 M	Date **Payor Receipt Date** Date (YYMMDD). **The date on which this claim was received by the payor.**	**450-09** **(last 6 digits)**
DTM03 0337	Time **Not Used.**	
DTM04 0623	Time Code **Not Used.**	
DTM05 0624 NO 2 2 M	Century The first two characters in the designation of the year (CCYY).	**450-09** **(first 2 digits)**
DTM06 1250	Date Time Period Format Qualifier **Not Used.**	
DTM07 1251	Date Time Period **Not Used.**	

X12 Segment Name: **AMT Monetary Amount**
Loop: CLP
Max. Use: 20
X12 Purpose: To indicate the total monetary amount.
Usage: **Conditional**
Example: AMT*I*.56~
Comments: This segment is used to convey information only and is not part of the financial balancing.

Element Attributes	Data Element Usage	NSF Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount **For Medicare, "I" in AMT01 is the amount of interest paid for this claim not included in net reimbursement but reflected in the provider payment (BPR02) through the PLB segment with adjustment reason code "I". Interest reported in this segment should be positive. "F5" is used to report the amount the patient has already paid.** Codes: **I Interest** **F5 Patient Amount Paid** **Monetary amount value already paid by one receiving medical care**	**TG**
AMT02 0782 R 1 15 M	Monetary Amount **Monetary amount.** Interest Amount/Patient Paid Amount	**I = 500-11** **GS = 500-29**
AMT03 0478	Credit/Debit Flag Code **Not Used.**	

X12 Segment Name: **SVC Service Information**
Name: **Claim Service Line Data**
Loop: SVC
Max. Use: 1
X12 Purpose: To supply payment and control information to a provider for a particular service.
Usage: **Mandatory**
Example: SVC*HC>99214*300*200~

Semantic Note: SVC01 is the Medical Procedure upon which adjudication is based.
Semantic Note: SVC02 is the submitted service charge.
Semantic Note: SVC03 is the amount paid this service.
Semantic Note: SVC04 is the National Uniform Billing Committee Revenue Code.
Semantic Note: SVC05 is the paid Units of Service.
Semantic Note: SVC06 is the original submitted Medical Procedure.
Semantic Note: SVC07 is the original submitted Units of Service.

X12 Comment: For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).

Element Attributes	Data Element Usage	NSF Mapping
SVC01 C003 Composite M	Composite Medical Procedure Identifier Medicare Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers.	
***-01** 0235 ID 2 2 M	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234). Codes: **HC -- Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare. Primarily used for ambulatory surgical and other diagnostic departments.**	**TG**

***-02** 0234 AN 1 40 M	Product/Service ID **Procedure Code** Identifying number for a product or service. **The processed HCPCS procedure code for this service.**	**450-13**
***-03** 1339 AN 2 2 C	Procedure Modifier **HCPCS Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **HCPCS modifier code for this procedure.**	**450-14**
***-04** 1339 AN 2 2 C	Procedure Modifier **HCPCS Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **HCPCS modifier code for this procedure.**	**450-15**
***-05** 1339 AN 2 2 C	Procedure Modifier **HCPCS Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **HCPCS modifier code for this procedure.**	**450-16**
***-06** 1339	Procedure Modifier **Not Used.**	
***-07** 0352	Description **Not Used.**	
SVC02 0782 R 1 15 M	Monetary Amount **Line Submitted Charge** Monetary amount. **The submitted charge for this service.**	**450-18**

SVC03 0782 R 1 15 M	Monetary Amount **Line Paid Amount** Monetary amount. **The paid amount for this service, excluding any late filing charges.**	**450-28**
SVC04 0234	Product/Service ID **Not Used.**	
SVC05 0380 R 1 15 C	Quantity **Paid Units of Service** Numeric value of quantity. **The number of services in days or units that were paid. If left blank, default will be zero.**	**450-17**
SVC06 C003 Composite C	Composite Medical Procedure Identifier **Medicare Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers.	
***-01** 0235 ID 2 2 M	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234). Codes: **HC -- Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare. Primarily used for ambulatory surgical and other diagnostic departments.**	**TG**
***-02** 0234 AN 1 40 C	Product/Service ID **Submitted Procedure Code** Identifying number for a product or service. **The submitted procedure code if the carrier changed the procedure code for payment or adjudication purposes.**	**451-09**

***-03** 1339	Procedure Modifier **Not Used.**	
***-04** 1339	Procedure Modifier **Not Used.**	
***-05** 1339	Procedure Modifier **Not Used.**	
***-06** 1339	Procedure Modifier **Not Used.**	
***-07** 0352	Description **Not Used.**	
SVC07 0380 R 1 15 C	Quantity **Submitted Units of Service** Numeric value of quantity. **The submitted number of services in days or units if the carrier processed a different number of units.**	**451-25**

X12 Segment Name: **DTM Date/Time Reference**
Name: **Service Date(s)**
Loop: SVC
Max. Use: 9
X12 Purpose: To specify pertinent dates and times
Purpose: To convey the starting date of service or the date of a service completed in one day.
Usage: **Mandatory**
Example: DTM*472*970127***19~
Comments: Report the ending date of a service occurring over multiple days in the 2-080.B DTM segment.

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.
Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element Attributes	Data Element Usage	NSF Mapping
DTM01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. **Use 472 to indicate a one-day service.** **Use 150 to indicate the start date of a service occurring over multiple days.** Codes: **150 Service Period Start** **472 Service**	**TG**
DTM02 0373 DT 6 6 M	Date **Service Date** Date (YYMMDD). **To report a single date of service or the start date of a service occurring over multiple days.**	**450-07** **(last 6 digits)**
DTM03 0337	Time **Not Used.**	
DTM04 0623	Time Code **Not Used.**	
DTM05 0624 NO 2 2 M	Century The first two characters in the designation of the year (CCYY).	**450-07** **(first 2 digits)**

DTM06 1250 Date Time Period Format Qualifier
Not Used.

DTM07 1251 Date Time Period
Not Used.

X12 Segment Name: **DTM Date/Time Reference**
Name: **Service Date**
Loop: SVC
Max. Use: 9
X12 Purpose: To specify pertinent dates and times
Purpose: **To convey the ending date of service when the service is not completed in one day.**
Usage: **Conditional**
Example: DTM*151*970128***19~

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.
Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element Attributes	Data Element Usage	NSF Mapping
DTM01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes: **151 Service Period End**	**TG**
DTM02 0373 DT 6 6 C	Date **Service Date** Date (YYMMDD). **To report service end date unique from start date.**	**450-08** **(last 6 digits)**
DTM03 0337	Time **Not Used.**	
DTM04 0623	Time Code **Not Used.**	
DTM05 0624 NO 2 2 M	Century The first two characters in the designation of the year (CCYY).	**450-08** **(first 2 digits)**
DTM06 1250	Date Time Period Format Qualifier **Not Used.**	
DTM07 1251	Date Time Period **Not Used.**	

X12 Segment Name: **CAS Claims Adjustment**
Name: **Line-level Adjustments**
Loop: SVC
Max. Use: 99
X12 Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.
Purpose: **To supply line-level adjustment reasons, amounts, and quantities.**
Usage: **Conditional**
Example: CAS*PR*2*1.3~
Comments: ***1. Service-level payment adjustments are indicated in this segment. Adjustments should be entered in the sequence they are applied by the payor's system.
***2. Each line-level adjustment amount relates to the immediately preceding adjustment reason code.
***3. Use the applicable reason code described in the ANSI ASC X12 reason code list (appendix C).
***4. Additions to payment are shown with a negative sign. Reductions to payment are positive.
***5. If CAS03 is mapped to a NSF field where the name of that NSF field supplies the reason, do not map CAS02. Hard Code the appropriate code (see Appendix B for further explanation).

Syntax Note: L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 must be present.
Syntax Note: C0605 - If CAS06 is present, then CAS05 must be present.
Syntax Note: C0705 - If CAS07 is present, then CAS05 must be present.
Syntax Note: L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 must be present.
Syntax Note: C0908 - If CAS09 is present, then CAS08 must be present.
Syntax Note: C1008 - If CAS10 is present, then CAS08 must be present.
Syntax Note: L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 must be present.
Syntax Note: C1211 - If CAS12 is present, then CAS11 must be present.
Syntax Note: C1311 - If CAS13 is present, then CAS11 must be present.
Syntax Note: L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 must be present.
Syntax Note: C1514 - If CAS15 is present, then CAS14 must be present.
Syntax Note: C1614 - If CAS16 is present, then CAS14 must be present.
Syntax Note: L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 must be present.
Syntax Note: C1817 - If CAS18 is present, then CAS17 must be present.
Syntax Note: C1917 - If CAS19 is present, then CAS17 must be present.

Semantic Note: CAS03 is the amount of adjustment.
Semantic Note: CAS04 is the units of service being adjusted.
Semantic Note: CAS06 is the amount of the adjustment.
Semantic Note: CAS07 is the units of service being adjusted.
Semantic Note: CAS09 is the amount of the adjustment.
Semantic Note: CAS10 is the units of service being adjusted.
Semantic Note: CAS12 is the amount of the adjustment.
Semantic Note: CAS13 is the units of service being adjusted.
Semantic Note: CAS15 is the amount of the adjustment.
Semantic Note: CAS16 is the units of service being adjusted.
Semantic Note: CAS18 is the amount of the adjustment.
Semantic Note: CAS19 is the units of service being adjusted.

X12 Comment: Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
X12 Comment: When the submitted charges are paid in full, the value for CAS03 should be zero.

Element Attributes	Data Element Usage	NSF Mapping
CAS01 1033 ID 1 2 M	Claim Adjustment Group Code Code identifying the general category of payment adjustment. Codes: **PR Patient Responsibility Adjustment** - Any adjustment where the patient will be assuming or has assumed financial responsibility. **CR Correction** - Change to a previously processed claim. **OA Other adjustment** - Any other adjustment. Do not include any adjustment for which the patient or provider has financial liability. **CO Contractual Obligations** - Payment adjustment where the provider did not meet a program requirement and is financial liability.	**450-38 to 450-44 (first 2 spaces) or TG: PR 450-22, 450-23 OA 450-33 CO 450-25**
CAS02 1034 ID 1 5 M	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**450-38 to 450-44 (spaces 3 - 6) or TG for 450-22 450-23 450-25 450-33**
CAS03 0782 R 1 15 M	Monetary Amount **Line Adjustment Amount** Monetary amount.	**450-22 (PR), 450-23 (PR) 450-33 (OA) 451-10 to 451-14 451-22, 451-23**
CAS04 0380	Quantity **Not Used.**	
CAS05 1034 ID 1 5 C	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**

CAS06 0782 R 1 15 C	Monetary Amount **Line Adjustment Amount** Monetary amount.	**See CAS 03**
CAS07 0380	Quantity **Not Used.**	
CAS08 1034 ID 1 5 C	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS09 0782 R 1 15 C	Monetary Amount **Line Adjustment Amount** Monetary amount.	**See CAS 03**
CAS10 0380	Quantity **Not Used.**	
CAS11 1034 ID 1 5 C	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS12 0782 R 1 15 C	Monetary Amount **Line Adjustment Amount** Monetary amount.	**See CAS 03**
CAS13 0380	Quantity **Not Used.**	
CAS14 1034 ID 1 5 C	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**

CAS15 0782 R 1 15 C	Monetary Amount **Line Adjustment Amount** Monetary amount.	**See CAS 03**
CAS16 0380	Quantity **Not Used.**	
CAS17 1034 ID 1 5 C	Claim Adjustment Reason Code **Line Adjustment Reason Code** Code identifying the detailed reason for the adjustment being made. **See codes in Appendix C.**	**See CAS 02**
CAS18 0782 R 1 15 C	Monetary Amount **Line Adjustment Amount** Monetary amount.	**See CAS 03**
CAS19 0380	Quantity **Not Used.**	

X12 Segment Name: **REF Reference Numbers**
Name: **Place of Service**
Loop: SVC
Max. Use: 99
X12 Purpose: To specify identifying numbers.
Purpose: **To convey the place of service for the previous SVC segment.**
Usage: **Mandatory**
Example: REF*LU*11~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **LU Location Number**	**TG**
REF02 0127 AN 1 30 M	Reference Number **Place of Service Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **The code that identifies where the service was performed. Two digit HCFA place of service as follows:** **11 Office** **12 Home** **21 Inpatient Hospital** **22 Outpatient Hospital** **23 Emergency Room - Hospital** **24 Ambulatory Surgical Center** **25 Birthing Center** **26 Military Treatment Facility** **31 Skilled Nursing Facility** **32 Nursing Facility** **33 Custodial Care Facility** **34 Hospice** **41 Ambulance - Land** **42 Ambulance - Air or Water** **50 Federally Qualified Health Center** **51 Inpatient Psychiatric Facility** **52 Psychiatric Facility Partial Hospitalization**	**450-11**

53 Community Mental Health Center
54 Intermediate Care Facility / Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

REF03 0352 Description
Not Used.

X12 Segment Name: **REF Reference Numbers**
Name: **Performing Provider ID**
Loop: SVC
Max. Use: 99
X12 Purpose: To specify identifying numbers.
Purpose: **To identify the performing provider for the previous SVC segment.**
Usage: **Conditional**
Example: REF*1C*78901234~
Comments: If the performing provider is the same as the billing provider in 1-080-N1, do not send this segment.

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **1C Medicare Provider Number**	**TG**
REF02 0127 AN 1 30 M	Reference Number **Performing Provider Number** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. The carrier-assigned performing provider number. **Use the NPI when effective.**	**450-37**
REF03 0352	Description **Not Used.**	

X12 Segment Name: **REF Reference Numbers**
Name: **Facility / Supplier ID**
Loop: SVC
Max. Use: 99
X12 Purpose: To specify identifying numbers.
Purpose: **To identify the facility for the previous SVC segment.**
Usage: **Conditional**
Example: REF*1J*450420~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **1J Facility ID Number**	**TG**
REF02 0127 AN 1 30 M	Reference Number **Facility ID** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **The carrier-assigned facility ID of the location where the service was performed. This will be the NPI when effective.**	**450-36**
REF03 0352	Description **Not Used.**	

X12 Segment Name: **REF Reference Numbers**
Name: **Provider Control Number**
Loop: SVC
Max. Use: 99
X12 Purpose: To specify identifying numbers.
Purpose: **To identify the control number assigned by the provider for the previous SVC segment.**
Usage: **Conditional**
Example: REF*6R*450420~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	NSF Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **FJ Line Item Control Number**	**TG**
REF02 0127 AN 1 30 M	Reference Number **Provider Control Number** Reference number or identification number assigned by the provider for this service and submitted on the claim.	**450-04**
REF03 0352	Description **Not Used.**	

X12 Segment Name: **AMT Monetary Amount**
Name: **Medicare Allowed Amount**
Loop: SVC
Max. Use: 20
X12 Purpose: To indicate the total monetary amount.
Purpose: **To convey the Medicare allowed amount for the previous SVC segment.**
Usage: **Mandatory**
Example: AMT*B6*200~

Element Attributes	Data Element Usage	NSF Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount Codes: **B6 Allowed - Actual Amount considered for payment under the provisions of the contract**	**TG**
AMT02 0782 R 1 15 M`	Monetary Amount **Medicare Allowed Amount** Monetary amount. The amount must be conveyed using the same format as for all other monetary amounts (Ele # 782).	**450-21**
AMT03 0478	Credit/Debit Flag Code **Not Used.**	

X12 Segment Name: **AMT Monetary Amount**
Name: **Late Filing Reduction**
Loop: SVC
Max. Use: 20
X12 Purpose: To indicate the total monetary amount.
Purpose: **To convey the Medicare late filing charges.**
Usage: **Conditional**
Example: AMT*KH*10~

Element Attributes	Data Element Usage	NSF Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount Codes: **KH Deduction Amount**	**TG**
AMT02 0782 R 1 15 M	Monetary Amount **Late Filing Reduction** Monetary amount. **The amount must be conveyed using the same format as for all other monetary amounts (Ele # 782).**	**451-07**
AMT03 0478	Credit/Debit Flag Code **Not Used.**	

X12 Segment Name: **LQ Industry Code**
Name: **Reference Line-level Remark Codes**
Loop: SVC
Max. Use: 99
Purpose: **To supply service-specific informational messages that cannot be expressed with a CAS reason code.**

Usage: **Conditional**
Example: LQ*HE*M1~
Comments: ***1. Use the applicable HCFA maintained Reference Remark Codes.
***2. A limitation of liability message (M25-M27) must be used where applicable.

Element Attributes	Data Element Usage	NSF Mapping
LQ01 1270 ID 1 3 M	Code List Qualifier Code Codes: **HE -- Health Care Financing Administration Claim Payment Remark Codes**	**TG**
LQ02 1271 AN 1 30 M	Industry Code **Reference-Line Remark Codes** **The HCFA maintained remark code to convey service-specific information that does not involve a financial adjustment. Use standard code list (appendix C). Line level remark codes begin with M and claim level remark codes begin with MA.** **When using code M16, which requires the date of a letter or bulletin, write "M16 - CCYYMMDD".**	**451-16 to 451-20** **with 451-21 (if a date is required)**

X12 Segment Name: **PLB Provider Level Adjustment**
Name: **Provider-level Adjustments**
Loop: ----
Max. Use: 99
X12 Purpose: To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service.
Purpose: **To convey provider-level adjustment reasons and amounts. These are adjustments to the total provider payment that are not attributable to a specific claim or service. (Service-level adjustments are provided in the CAS segment in the SVC loop and claim-level adjustments are provided in the CAS segment in the CLP loop.)**
Usage: **Conditional**
Example: PLB*78901234*971231*OF7849316*179.14~
Comments: ***1. All provider-level adjustments to the payment amount must be indicated in this segment (use more than one iteration of the segment if necessary). Adjustments should be entered in the sequence they are applied by the payor's system.
***2. Each provider adjustment amount relates to the immediately preceding adjustment reason code.
***3. The adjustment reason codes are constructed as described in PLB03.
***4. When reporting interest, the financial control number and HIC number are not used.
***5. Any adjustments increasing payment, such as interest, should be reported as negative. Any adjustments decreasing payment, such as withholdings and penalties, should be reported as positive.

Syntax Note: P0506 - If either PLB05 or PLB06 is present, then the other must be present.
Syntax Note: P0708 - If either PLB07 or PLB08 is present, then the other must be present.
Syntax Note: P0910 - If either PLB09 or PLB10 is present, then the other must be present.
Syntax Note: P1112 - If either PLB11 or PLB12 is present, then the other must be present.
Syntax Note: P1314 - If either PLB13 or PLB14 is present, then the other must be present.

Semantic Note: PLB01 is the provider number assigned by the payer.
Semantic Note: PLB02 is the last day of the providers fiscal year.
Semantic Note: PLB03 is the adjustment information as defined by payer.
Semantic Note: PLB04 is the adjustment amount.
Semantic Note: PLB05 is the adjustment information as defined by payer.
Semantic Note: PLB06 is the adjustment amount.
Semantic Note: PLB07 is adjustment information as defined by payer.
Semantic Note: PLB08 is the adjustment amount.
Semantic Note: PLB09 is adjustment information as defined by payer.
Semantic Note: PLB10 is the adjustment amount.
Semantic Note: PLB11 is adjustment information as defined by payer.
Semantic Note: PLB12 is the adjustment amount.
Semantic Note: PLB13 is adjustment information as defined by payer.
Semantic Note: PLB14 is the adjustment amount.

Element Attributes	Data Element Usage	NSF Mapping
PLB01 0127 AN 1 30 M	Reference Number **Provider Number** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **The carrier-assigned billing provider number for which an adjustment is being made by the payer. The National Provider Identifier (NPI) must be entered here when effective.**	**200-07**
PLB02 0373 DT 6 6 M	Date **End of Calendar Year** Date (YYMMDD). Shows last date of the current calendar year (YY1231).	**TG**
PLB03 0127 AN 1 30 M	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. PLB03 is used to convey 2 or 3 pieces of information. Position 1 and 2 will always contain one of the following codes: **AP Advance Payment** **BF Balance Forwarded** **LP Student Loan Repayment** **OF Offset** **IL IRS Levy** **WH IRS Withholding** **IN Interest** **RI Void/Reissue** **AJ Adjustment** **RF Refund** **LF Late Filing Reduction** **J1 Non-Reimbursable**	**700-06**
	Positions 3 to 19 should contain the Carrier's assigned Financial Control Number when such a number exists. This number is used by the Carrier to identify a specific financial transaction adjustment.	**700-08**

	Positions 20 to 30 may contain the patient's Health Insurance Claim (HIC) number, when the adjustment is related to a previously processed claim.	**700-04**
PLB04 0782 R 1 15 M	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**700-07**
PLB05 0127 AN 1 30 C	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **See PLB03.**	**See PLB 03**
PLB06 0782 R 1 15 C	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**See PLB 04**
PLB07 0127 AN 1 30 C	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **See PLB03.**	**See PLB 03**
PLB08 0782 R 1 15 C	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**See PLB 04**
PLB09 0127 AN 1 30 C	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **See PLB03.**	**See PLB 03**

PLB10 0782 R 1 15 C	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**See PLB 04**
PLB11 0127 AN 1 30 C	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **See PLB03.**	**See PLB 03**
PLB12 0782 R 1 15 C	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**See PLB 04**
PLB13 0127 AN 1 30 C	Reference Number **Provider Adjustment Reason Code** Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. **See PLB03.**	**See PLB 03**
PLB14 0782 R 1 15 C	Monetary Amount **Provider Adjustment Amount** Monetary amount.	**See PLB 04**

X12 Segment Name: **SE Transaction Set Trailer**
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).
Usage: **Mandatory**
Example: SE*52*0019~

X12 Comment: SE is the last segment of each transaction set.

Element Attributes	Data Element Usage	NSF Mapping
SE01 0096 N0 1 10 M	Number of Included Segments **Transaction Segment Count** Total number of segments included in a transaction set including ST and SE segments.	**TG**
SE02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. **The transaction set control number, SE02, must be identical to the same data element in the associated transaction set header, ST02.**	**200-05, 800-05**

X12 Segment Name: **GE Functional Group Trailer**
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of a functional group and to provide control information.
Usage: **Mandatory**
Example: GE*1*1~

Semantic Note: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated Functional Header GS06.

X12 Comment: The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Element Attributes	Data Element Usage	NSF Mapping
GE01 0097 N0 1 6 M	Number of Transaction Sets Included **Group Set Count** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	**TG**
GE02 0028 N0 1 9 M	Group Control Number Assigned number originated and maintained by the sender. **The Group Control Number, GE02, must be identical to the one found in the associated functional header GS06.**	**Translator Generated**

X12 Segment Name: **IEA Interchange Control Trailer**
Loop: ----
Max. Use: 1
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments.
Usage: **Mandatory**
Example: IEA*1*000000905~

Element Attributes	Data Element Usage	NSF Mapping
IEA01 I16 N0 1 5 M	Number of Included Functional Groups **Transmission Group Count** A count of the number of functional groups included in an interchange	**TG**
IEA02 I12 N0 9 9 M	Interchange Control Number A control number assigned by the interchange sender. **The Interchange Control Number, IEA02, must be identical to the one found in The associated Interchange Header ISA13.**	**TG**

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NSF Data Dictionary

In most cases, these definitions are taken word for word from the Electronic Remittance Notices National Standard Format, National Version 002.01 [NSF]. The name of each field and the field number appear to the left of the definition. Some editing has been done, primarily in cases where a definition was applied to a group of fields rather than each individual field. The cobol picture from the NSF is also provided at the end of each definition. Each field defined below is listed in sequential order by field number in the next appendix (Appendix B). The second half of Appendix B provides a map from every NSF field to the 835. Definitions of the 835 elements can be found in the Implementation Detail in Part IV. NSF mappings are also given in the Implementation Detail, along with the attributes of the 835 elements.

Actual Payment to Payee
(450-33) The actual amount paid to the payee, other than the provider. [S9(05)V99]

Actual Payment to Provider
(450-32) The actual amount paid to the provider. [S9(05)V99]

Adjustment Amount
(700-07) Provider adjustment amount. The adjustment amount is to the total provider payment and is not related to a specific claim or service. [S9(05)V99]

Allowed/Contract Amount
(450-21) The maximum amount determined by the payor as being "allowed" under the provisions of the contract prior to the determination of actual payment, for this line. [S9(05)V99]

Amount Paid by Other Payor
(450-26) The amount paid by other payor, for this line. [S9(05)V99]

Amount Patient Owes
(451-08) The portion of the charge for this service that is the patient's financial responsibility. [S9(05)V99]

Amount Patient Paid
(451-24) The amount paid by the patient for this service. [S9(05)V99]

BT Actual Payment to Payee
(800-23) The actual payment to the payees (other than the providers) for this batch. [S9(07)V99]

BT Actual Payment to Provider
(800-22) The actual payment to the provider for this batch. [S9(07)V99]

BT Allowed
(800-11) The maximum payment amount determined by the payor as being "allowed" under the provisions of the contract prior to the determination of the actual payment, for this batch. [S9(07)V99]

BT Amount Paid Other Payor
(800-16) The total amount paid by other payors, for this batch. [S9(07)V99]

BT Amount Patient Owes
(800-25) The total amount of charges that is patient financial responsibility, for this batch. [S9(07)V99]

BT Amount Patient Paid
(800-29) The total amount paid by the patient, for this this batch. [S9(07)V99.

BT Calculated Payment to Payee
(800-19) The total calculated payments to the payees, (other than the providers), for this batch. [S9(07)V99]

BT Calculated Payment to Provider
(800-18) The calculated total payment to the provider for this batch. [S9(07)V99]

BT Claim Records
(800-06) The number of "400" patient claim data records in this batch. [9(05)]

BT Coinsurance
(800-13) The amount deducted from this batch, by the payor, from the allowed amount in order to meet the "co-insurance" provisions of the contract. [S9(07)V99]

BT Deductible
(800-12) This is the amount applied to the deductible by this payor, for this batch. [S9(07)V99]

BT Disallow-Cost Containment

(800-09) The total of the line charges for this batch disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provision of the insurance contract, managed care contract or PPO contract under which payment has been requested for the beneficiaries. [S9(07)V99]

BT Disallow/Noncover

(800-10) The total of the line charges for this batch disallowed by the payor for reasons other than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested. [S9(07)V99]

BT Gramm-Rudman Reduction

(800-15) The total amount of the Gramm-Rudman reduction, for this batch. [S9(07)V99]

BT Interest Paid

(800-14) The total interest applied to this batch. [S9(07)V99]

BT Late Filing Reduction

(800-24) The total amount applied to the Late Filing Reduction, for this batch. [S9(07)V99]

BT Previous Payment to Payee

(800-21) The amount previously paid to payees (other than the providers) for claims in this batch. [S9(07)V99]

BT Previous Payment to Provider

(800-20) The amount previously paid to the provider for claims in this batch. [S9(07)V99]

BT Provider Adjustment

(800-17) The total adjusted amount applied to this batch. [S9(07)V99]

BT Service Data Records

(800-07) The number of "450" SERVICE DATA - 1 records in this batch. [X(05)]

BT Submitted Charges

(800-08) The total submitted charges of the line items for this batch. [S9(07)V99]

BT Total Provider Adjustment Amount

(800-28) The total provider adjustment amount not related to a specific claim or service, for this batch. [S9(07)V99]

BT Total Provider Adjustment Records

(800-27) The number of "700" provider adjustment data records in this batch. [9(05)]

Batch Number

(200-05, 800-05) A sequential number assigned to each batch of claims by the entity that generated this file. [9(04)]

CT Actual Payment to Payee

(500-20) The actual payment to the payee (other than the provider) for this claim. [S9(05)V99]

CT Actual Payment to Provider

(500-19) The actual payment to the provider for this claim. [S9(05)V99]

CT Allowed

(500-08) The maximum amount for the claim determined by the payor as being "allowed" for the claim under the provisions of the contract prior to the determination of actual payment, for this claim. [S9(05)V99]

CT Amount Paid by Other Payor

(500-13) The amount paid by another payor, for this claim. [S9(05)V99]

CT Amount Patient Owes

(500-23) The total amount applied to the Amount Patient Owes, for this claim. [S9(05)V99]

CT Amount Patient Paid

(500-27) The total amount paid by the patient, for this this claim. [S9(05)V99.

CT Calculated Payment to Payee

(500-16) The calculated payment to the payee (other than the provider), for this claim. [S9(05)V99]

CT Calculated Payment to Provider

(500-15) The calculated payment to the provider, for this claim. [S9(05)V99]

CT Coinsurance

(500-10) The amount deducted from this claim, by the payor, from the allowed amount in order to meet the "co-insurance" provisions of the contract. The amount applied toward the coinsurance by this payor. [S9(05)V99]

CT Deductible

(500-09) This is the amount applied to the deductible by this payor, for this claim. Or, the amount deducted, by the payor, from the allowed amount in order to meet the deductible contract provisions. [S9(05)V99]

CT Disallow-Cost Containment

(500-06) The total of the line charges for this patient disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provision of the insurance contract, managed care contract or PPO contract under which payment has been requested for this patient. [S9(05)V99]

CT Disallow/Noncover

(500-07) The total of the line charges for this patient disallowed by the payor for reasons other than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this patient. [S9(05)V99]

CT Gramm-Rudman Reduction

(500-12) The amount applied to the Gramm-Rudman reduction, for this claim. [S9(05)V99]

CT Interest Paid

(500-11) The interest applied to this claim. [S9(05)V99]

CT Late Filing Reduction

(500-22) The total amount applied to the Late Filing Reduction, for this claim. [S9(05)V99]

CT Line Items

(500-04) The number of "450" service line items for this patient. [9(03)]

CT Previous Payment to Payee

(500-18) The amount previously paid to the payee (other than the provider) for this claim. [S9(05)V99]

CT Previous Payment to Provider

(500-17) The amount previously paid to the provider for this claim. [S9(05)V99]

CT Provider Adjustment

(500-14) The adjusted amount applied to this claim. [S9(05)V99]

CT Submitted Charges

(500-05) The total submitted charges of the line items for this patient. [S9(05)V99]

Calculated Payment to Payee

(450-29) The calculated payment to the payee (other than the Provider) for this line. [S9(05)V99]

Calculated Payment to Provider

(450-28) The calculated payment to provider, for this line. [S9(05)V99]

Carrier/Supplemental Insurer/Name1 and 2

(500-25 and 500-27) The name of the carrier name or supplemental insurer to whom the claim were crossed over were crossed over or transferred. [X(33)]

Check Number/EFT Tracer Number

(200-08, 400-04) The number of the check, EFT tracer number or statement issued to the provider for this batch of claims. [X(15)]

Check/EFT Issue Date

(200-09, 400-05) The date the check or statement was issued. [X(08)]

Claim Dollar Adjustment Amount 1 - 3

(500-33 - 500-35) Claim adjustment amount relating to the reason codes (fields 400-28.0, 400-29.0 and 400-30.0). [S9(05)V99]

Claim Filing Indicator

(500-24) A code indicating whether the provider accepted assignment. [X(01)]

Claim Remark Code 1 - 5

(400-23 - 400-27) Claim level informational message codes to convey appeal or other claim-specific information that does not involve a financial adjustment. [X(05)]

Claim Adjustment Reason Code 1 - 3

(500-30 - 500-32) Claim adjustment reason codes. The codes show the reasons for any adjustments, such as denials or reductions in payment from the amount billed, that are made on claims and may have a financial effect. [X(06)]

Claim Status

(400-19) This is a code indicating the status of this claim as determined by the payor. [X(02)]

Coinsurance Amount

(450-23) The amount deducted from this line, by the payor, from the allowed amount in order to meet the "coinsurance" provisions of the contract. Or, the amount applied toward the coinsurance by this payor. [S9(05)V99]

Complementary Insurance Flag

(400-18) A code which identifies complementary insurance action. [X(01)]

Corrected Insured Identification Indicator

(400-08) An indicator used to identify an Insured's identification number which was incorrectly submitted and subsequently changed. [X(01)]

Deductible Amount

(450-22) This is the amount applied to deductible by this payor, for this line. Or, the amount deducted, by the payor, from the allowed amount in order to meet the contract deductible provisions. [S9(05)V99]

Disallowed Cost Containment

(450-19) The portion of line charges disallowed by the payor due to the failure of either the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this line. [S9(05)V99]

Disallowed/Noncovered
(450-20) The portion of line charges disallowed by the payor for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested for this line. [S9(05)V99]

Dollar Amount 1 - 5
(451-10 - 451-14) The amount relating to the claim adjustment reason codes (1 - 5) on the 450 record (fields 450-38 - 450-42). [S9(05)V99]

Dollar Amount 6 - 7
(451-22 - 451-23) The amount relating to the claim adjustment reason codes (6 - 7) on the 450 record (fields 450-43 - 450-44). [S9(05)V99]

EMC Provider Identifier
(200-04, 800-04) The unique number assigned to the provider by the payor for EMC identification purposes. [X(15)]

Employee Identification
(400-12) The identification number assigned by the employer to the employee. [X(12)]

FT Actual Payment to Payee
(900-24) The total amount actually paid to payees (other than the provider[s]), for this file. [S9(09)V99]

FT Actual Payment to Provider
(900-23) The total amount actually paid to the provider(s), for this file. [S(09)V99]

FT Allowed
(900-12) The maximum payment amount determined by the payors as being "allowed" under the provisions of the contract prior to the determination of the actual payment, for this file. [S9(09)V99]

FT Amount Paid Other Payor
(900-17) The total amount paid by other payors, for this file. [S9(09)V99]

FT Amount Patient Owes
(900-26) The total amount of charges that is patient financial responsibility, for this file. [S9(09)V99]

FT Amount Patient Paid
(900-27) The total amount paid by the patient, for this file. [S9(05)V99.

FT Batches
(900-07) The number of "200" batch records in this file. [9(05)]

FT Calculated Payment to Payee
(900-20) The total calculated payments to the payees (other than the provider[s]), for this file. [S9(09)V99]

FT Calculated Payment to Provider
(900-19) The calculated total payments to the provider(s), for this file. [S9(09)V99]

FT Coinsurance
(900-14) The amount deducted from this file, by the payors, from the allowed amount in order to meet the "co-insurance" provisions of the contract. The amount applied toward the coinsurance by the payors. [S9(09)V99]

FT Deductible
(900-13) This is the amount applied to the deductible by the payors, for this file. [S9(09)V99]

FT Disallow-Cost Containment
(900-10) The total of the line charges for this file disallowed by the payors due to the failure of either the provider or insured to meet the cost containment provision of the insurance contract, managed care contract or PPO contract under which payment has been requested for the beneficiaries. [S9(09)V99]

FT Disallow/Noncover
(900-11) The total of the line charges for this file disallowed by the payors for reasons other than the failure of the provider or insured to meet the cost containment provisions of the insurance contract, managed care contract or PPO contract under which payment has been requested. [S9(09)V99]

FT Gramm-Rudman Reduction
(900-16) The total amount of the Gramm-Rudman reduction, for this file. [S9(09)V99]

FT Interest Paid
(900-15) The total interest applied to this file. [S9(09)V99]

FT Late Filing Reduction
(900-25) The total amount applied to the Late Filing Reduction, for this file. [S9(09)V99]

FT Patient Records
(900-08) The total number of "400" claims in this file. [9(06)]

FT Previous Payment to Payee
(900-22) The total amount previously paid to payees (other than the provider[s]), for this file. [S9(09)V99]

FT Previous Payment to Provider
(900-21) The total amount previously paid to the provider(s), for this file. [S9(09)V99]

FT Provider Adjustment
(900-18) The total adjusted amount applied to this file. [S9(09)V99]

FT Provider Adjustment Amount
(900-30) The total provider adjustment amount not related to a specific service or claim, for this file. [S9(09)V99]

FT Provider Adjustment Records
(900-29) The number of "700" provider adjustment records in this file. [X(06)]

FT Submitted Charges
(900-09) The total submitted charges of the line items for this file. [S9(09)V99]

FT Total Offset Amount
(900-28) The total amount of offset, for this file. [S9(09)V99]

FT Total Refund Amount
(900-29) The total amount of refund, for this file. [S9(09)V99]

Facility/Supplier Identifier
(450-36) The identification number assigned to the facility or supplier. [X(15)]

File Creation Date
(100-08) The Gregorian date on which this file was created. [X(08)]

Filler-National, Record 100

(100-10) Unused record space reserved for national use. [X(214)]

Filler-National, Record 200

(200-19) Unused record space reserved for national use. [X(140)]

Filler-National, Record 400

(400-34) Unused record space reserved for national use. [X(62)]

Filler-National, Record 450

(450-46) Unused record space reserved for national use. [X(03)]

Filler-National, Record 451

(451-24) Unused record space reserved for national use. [X(130)]

Filler-National, Record 500

(500-36) Unused record space reserved for national use. [X(1)]

Filler-National, Record 700

(700-09) Unused record space reserved for national use. [X(235)]

Filler-National, Record 800

(800-26, 800-29) Unused record space reserved for national use. [X(102)]

Filler-National, Record 900

(900-28, 900-31) Unused record space reserved for national use. [X(23)]

Financial Control Number

(700-08) The Financial Control Number (FCN) assigned by the payor to identify a specific financial transaction adjustment. [X(17)]

Gramm-Rudman Reduction

(450-25) The amount applied to Gramm-Rudman reduction, for this line. [S9(09)V99]

Group Codes

(First two spaces of 450-38 thru 450-44) Code that specifies financial liability for an unpaid amount. [X(02)]

Group Policy Number
(400-06) Identification number assigned by the payor to the group plan through which the insurance is provided. [X(20)]

HCPCS Modifier 1
(450-14) This code identifies special circumstances related to the performance of the service listed in 450-13. [X(02)]

HCPCS Modifier 2
(450-15) This code identifies special circumstances related to the performance of the service listed in 450-13. [X(02)]

HCPCS Modifier 3
(450-16) This code identifies special circumstances related to the performance of the service listed in 450-13. [X(02)]

Health Insurance Claim Number
(700-04) The insured's unique identification number assigned by the payor, i.e., health insurance claim number, where the adjustment is related to a previously processed claim. [X(25)]

Identification Number1 and 2
(500-26, 500-28) A unique number that identifies the organization in 500-25, 500-27. [X(15)]

Insured First Name
(400-10) The first name of the insured. [X(12)]

Insured Identification Number
(400-07) Insured's unique identification number assigned by the payor. [X(25)]

Insured Last Name
(400-09) The surname of the insured. [X(20)]

Insured Middle Initial
(400-11) The middle initial of the insured. [X(01)]

Interest Amount
(450-24) The interest applied to this line. [S9(05)V99]

Late Filing Reduction
(451-07) The amount deducted from the Actual Payment to Provider (450-32.0) by the payor because the claim was not filed within the payor's timely filing guidelines. [S9(05)V99]

Line Item Control Number
(450-04, 451-04) An identifier assigned by the submitter/provider to this line item. [X(17)]

Line Item Status Code
(450-06) Line item status code. [X(02)]

Line Remark Code 1 - 5
(451-16 - 451-20) Remark codes to convey service-specific information that does not involve a financial adjustment. [x(05)]

Line Remark Code Date
(451-21) The date that corresponds to a particular remark code message. [X(08)]

Medical Record Number
(400-21) A number assigned by the provider to identify the patient's medical records. [X(17)]

National Drug Code
(451-15) This is the national drug identification number assigned by the Federal Drug Administration (FDA). [X(11)]

Original Procedure Code
(451-09) The original HCPCS/CPT-4 code that was submitted by the provider to describe the service rendered. [X(05)]

Original Units of Service
(451-25) The original units of service that was submitted by the provider (in days or units). [X(04)]

Patient Account Number
(700-05) The number assigned by the provider to identify the patient whose claim may have initiated an adjustment. [X(17)]

Patient Birth Date
(400-17) The date the patient was born. [X(08)]

Patient Control Number
(400-03, 450-03, 451-03, 500-03) A value assigned by the provider to identify the patient. [X(17)]

Patient First Name
(400-14) The first name of the individual to whom the services were provided. [X(12)]

Patient Last Name
(400-13) The surname of the individual to whom the services were provided. [X(20)]

Patient Middle Initial
(400-15) The middle initial of the individual to whom the services were provided. [X(01)]

Patient Sex
(400-16) Code indicating the sex of the patient. [X(01)]

Payment Format Code
(200-17) This code identifies the payment format in the ACH network. [X(03)]

Payment Level By Percent
(450-34) Payment level (100%, 80%, 62.5%). [9(4)V9]

Payment Method Code
(200-16) This code identifies the method for the movement of payment. [X(03)]

Payor Claim Control Number
(400-22, 450-45, 451-06, 500-21) A number assigned by the payor to identify a claim. Or, an Internal Control Number (ICN) assigned to claim by payor. [X(17)]

Payor Identification
(100-02, 200-02, 400-02,450-02, 451-02, 500-02 700-02, 800-02, 900-02) A unique number assigned to identify the entity that generated this file. [X(9)]

Payor Phone Number
(400-20) The telephone number of the payor. [X(10)]

Payor Process Date
(200-10) The date the payor generated the remittance advice. [X(08)]

Payor Receipt Date
(450-09) The Gregorian date claim was received by payor. [X(08)]

Performing Provider Identifier
(450-37) The identification number assigned to the performing physician. [X(15)]

Place of Service
(450-11) The code that identifies where the service was performed. [X(02)]

PPO/HMO Indicator
(450-35) An indicator than the provider has submitted the claim under a PPO/HMO agreement. [X(01)]

Previous Payment to Payee
(450-31) The amount previously paid to the payee (other than the provider) for this service. [S9(05)V99]

Previous Payment to Provider
(450-30) The amount previously paid to provider for this line item. [S9(05)V99]

Procedure Code
(450-13) This is the HCPCS/CPT-4 code that describes the service as adjudicated by the payor. [X(05)]

Provider Adjustment
(450-27) The adjusted amount applied to this line. [S9(05)V99]

Provider Adjustment Reason
(700-06) A code that indicates the reason for the provider level adjustment. [X(02)]

Provider Assignment Indicator
(500-24) A code indicating whether or not the provider accepted asignment. [X(01)]

Provider Name
(200-06) The name of the provider or organization receiving this batch of claims for payment. [X(33)]

Provider Number
(200-07) The number assigned to the provider by the payor for identification purposes. [X(15)]

Reason Code 1 through 7
(450-38 - 450-44) Line level adjustment reason codes. The codes show the reasons for any adjustments, such as denials or reductions in payment from the amount billed, that are made on this service and may have a financial effect. [x(06)]

Receiver Identification
(100-03, 900-03) Identifies the organization designated to receive this file. [X(16)]

Receiver/Provider Account Number
(200-12) The receiver's/provider's Bank Account Number into which these funds have been or will be deposited at the previously identified receiving depository finaincial institution. [X(15)]

Receiver/Provider Bank ID Number
(200-11) The American Banking Association Identification Number used to identify the receiving depository financial institution or provider's bank within the Federal Reserve System when an EFT is being sent. [X(15)]

Receiver/Provider Type of Account
(200-18) This code indicates the type of bank account for the account into which payment is being made. [X(02)]

Record Identifier "100"
(100-01) Field used to identify the "Receiver Data Record". [X(03)]

Record Identifier "200"
(200-01) Field used to identify the "Provider Data Record". [X(03)]

Record Identifier "400"
(400-01) Field used to identify the "Patient Claim Data Record". [X(03)]

Record Identifier "450"
(450-01) Field used to identify the "Service Data -1 Record". [X(03)]

Record Identifier "451"
(451-01) Field used to identify the "Service Data - 2 Record". [X(03)]

Record Identifier "500"
(500-01) The field used to identify the "Patient Claim Trailer Record". [X(03)]

Record Identifier "700"
(700-01) Field used to identify the "Batch Adjustment Record". [X(03)]

Record Identifier "800"
(800-01) The field used to identify the "Batch Trailer Record". [X(03)]

Record Identifier "900"
(900-01) The field used to identify the "File Trailer Record". [X(03)]

Reserved
(100-06, 900-06) Reserved unused record space for expansion of Submitter ID. [X(06)]

Reserved
(100-04, 900-04) Reserved unused record space for expansion of Receiver ID. [X(04)]

Reserved
(450-10) Unused reserved record space. [X(15)]

Sender/Payor Account Number
(200-14) Sender's/payor's bank account number from which funds have been or will be sent at the previously identified originating depository financial institution.[x(15)]

Sender/Payor Bank ID No
(200-13) The American Banking Association Identification Number used to identify the sender's/payor's depository financial institution within the Federal Reserve System when an EFT is being sent. [X(15)]

Service Line Number
(450-05, 451-05) Identifies the line relative to other lines in a claim. [9(03)]

Service from Date
(450-07) The date the service was initiated and the date the service extends through. [X(08)]

Service to Date
(450-08) The date the service was initiated and the date the service extends through. (X(08)]

Sequence Number
(700-03) Value to sequence the provider (batch level) adjustment record(s). (X(04)]

Source of Payment
(200-03, 800-03) A code identifying source of payment for this group of claims. [X(01)]

Submitted Line Charge
(450-18) The charges related to this service. [S9(05)V99]

Submitter Identification
(100-05, 900-05) Identifies the organization that created this remittance advice. [X(16)]

Submitter Name
(100-07) The name of the submitter to which the receiver should direct inquiries regarding this file. [X(33)]

Transaction Handling Code
(200-15) This code designates how the payment and remittance will be transmitted relative to the banking network. [X(01)]

Type of Service Code
(450-12) The code that classifies the service. [X(02)]

Units of Service
(450-17) The number of services rendered in days or units. [9(03)V9]

Sample Remittance Advice

NOTE: This example has deliberately been kept simple and may not convey all the complexities of Medicare Part B policy accurately.

From:	To:
Medicare Carrier # 03330	Medicare Provider # 123456
	Professional Association
EDI Exchange # 000000905	468 Main Street
Feb 18, 1997 @ 3:32 PM	Suite 111
EDI Receiver ID: MEDEX	Camp Hill, PA 17089

Adjustment applied: $100.00 Loan Repayment FCN 12357
Payment of $500.00 by CHECK # 345670 dated Feb 17, 1997

Patient Ref #	76543SMITH	Internal Control #	02M1234567
Patient Name:	John Smith	Paid as PRIMARY	
Patient HIC#:	321459876	Claim Total	$ 500.00
Date of Claim	Jan 28, 1997	Amount Paid	$ 200.00
Service # 1			
Date of Service :	Jan 27, 1997	Allowable:	200.00
Place of Service:	11	Deductible:	0.00
Procedure Code:	99214	Coinsurance:	0.00
Units:	1	Paid:	200.00
Charge:	300.00	Reasons:	
Provider ID:	78901234	Amount Above fee Schedule	
Service # 2			
Date of Service :	Jan 27, 1997	Allowable:	100.00
Place of Service:	11	Deductible:	100.00
Procedure Code:	99213	Coinsurance:	0.00
Units:	1	Paid:	0.00
Charge:	200.00	Reasons:	
Provider ID:	78901234	Amount Above fee Schedule	

Patient Ref #	12389JONES	Internal Control #	9702M1006751
Patient Name:	Ken C. Jones	Paid as PRIMARY	
Patient HIC#:	8761235490	Claim Total	$ 900.00
Date of Claim:	Jan 28, 1997	Amount Paid	$ 400.00
Service # 1			
Date of Service :	Jan 27, 1997	Allowable:	200.00
Place of Service:	11	Deductible:	0.00
Procedure Code:	99214	Coinsurance:	0.00
Units:	1	Paid:	200.00
Charge:	300.00	Reasons:	
Provider ID:	78901234	Amount Above fee Schedule	
Service # 2			
Date of Service :	Jan 27, 1997	Allowable:	300.00
Place of Service:	11	Adjustment:	50.00
Procedure Code:	99210	Coinsurance:	50.00
Units:	1	Paid:	200.00
Charge:	600.00	Reasons:	
Provider ID:	78901234	Usage guidelines not met.	

Remittance Advice Sample Mapping

	Comments
ISA*00*.....*00*.....*ZZ*9000000553.....*	0-010-ISA
...*ZZ*MEDEX.....*970218*1532*U*00305*000000905*0*T*>~	Wrap around
GS*HP*03330*MEDEX*970218*153206*1*X*003051~	0-020-GS
ST*835*0019~	1-010-ST
BPR*I*500*C*CHK*970524~	1-020-BPR
TRN*1*8765320*9000000770~	1-040-TRN
REF*F5*004~	1-060.A-REF
REF*EV*MEDEX~	1-060.B-REF
DTM*405*970217~	1-070-DTM
N1*PR*SOMEWHERE INSURANCE COMPANY*****~	1-080.A-NM1
N1*PE*PROFESSIONAL ASSOCIATION*MP*123456~	1-080.B-NM1
LX*1~	2-003.A-LX
CLP*76543SMITH*1*500*200*100*MB*9702M1234567~	2-010-CLP
CAS*OA*93*0~	2-020-CAS
NM1*QC*1*SMITH*JOHN****HN*321459876~	2-030.A-NM1
NM1*TT*2*SOMEWHERE INSURANCE CO*****PI*123456~	2-030.B-NM1
MOA***MA01~	2-035-MOA
DTM*050*970128~	2-050-DTM
AMT*I*.56~	2-062-AMT
SVC*HC>*99214*300*200~	2-070-SVC
DTM*150*970127~	2-080.A-DTM
DTM*151*970128~	2-080.B-DTM
CAS*PR*2*1.3~	2-090-CAS
REF*LU*11~	2-100.A-REF
REF*1C*78901234~	2-100.B-REF
REF*1J*450420~	2-100.C-REF
AMT*B6*200~	2-110.A-AMT
AMT*KH*10~	2-110.B-AMT
LQ*HE*M1~	2-130-LQ
PLB*78901234*971231*OF7849316*179.14~	3-010-PLB
SE*52*0019~	3-020-SE
GE*1*1~	4-010-GE
IEA*1*000000905~	4-020-IEA

==========

Actual 835 from Example

ISA*00* *00* *ZZ*9000000553.....* *ZZ*MEDEX
*970218*1532*U*00305*000000905*0*T*>~GS*HP*03330*MEDEX*970218*153206*1*X*003051~ST*835*0
019~BPR*I*500*C*CHK*970524~TRN*1*345670*03330~REF*F5*4B.00~REF*EV*MEDEX~DTM*405*97021
7~N1*PR*SOMEWHERE INSURANCE COMPANY***** ~N1*PE*PROFESSIONAL
ASSOCIATION*MP*123456~
~LX*1~CLP*76543SMITH*1*500*200*100*MB*9702M1234567~CAS*OA*93*0~NM1*QC*1*SMITH*JOHN*
HN*321459876~NM1*TT*2*SOMEWHERE INSURANCE CO**PI*123456~NM1*TT*2*SOMEWHERE
INSURANCE CO*****PI*123456~MOA**
*MA01~DTM*050*970128~AMT*I*.56~SVC*HC>*99214*300*200~DTM*150*970127~DTM*151*970128~C
AS*PR*2*1.3~REF*LU*11~REF*1C*78901234~REF*1J*450420~AMT*B6*200~AMT*KH*10~LQ*HE*M1~PL
B*78901234*971231*OF7849316*179.14~SE*52*0019~GE*1*1~IEA*1*000000905~

Conventions of the NSF to 835 Mapping

As mentioned in Part II, it is not possible to map from the NSF remittance to the 835 on a one-to-one basis. However, mapping from the NSF flat file is an essential part of implementing the 835 for Medicare Part B use. The mapping presented below was developed as a result of many different people's efforts. Explanation of the conventions for presentation of this thinking follow. While this is not the only possible way to map from the NSF to the 835, any departure from these recommendations should be avoided without consulting HCFA Central Office. NSF fields which do not correspond to the 835 are marked "Not Mapped" in this appendix. 835 elements with no NSF correspondence contain no entry in the NSF Mapping column in the Implementation Detail in Part 4.

The Envelope and the 835 - Translator Generated

The ASC X12 transaction envelope, which includes the ISA-GS-GE-IEA segments, is normally generated by the EDI translator. As such, the data are not normally mapped from the internal flat file, but from the translator's trading partner file (marked "translator generated" in Part IV). While some of this information is included in the NSF remittance format, no "map" is provided here to the segments which comprise the envelope. In addition, some information included in the envelope does not and cannot exist in the NSF file. The NSF file is expected only to identify the trading partner/receiver for the translation process.

CAS and PLB Segments

Both the CAS and PLB segments have repeating, grouped elements. CAS segments have six pairs of reason codes and adjustment amounts (CAS02-03, CAS05-06, CAS08-09, CAS11-12, CAS14-15, and CAS17-18). The PLB segment has six similar pairs (PLB03-04, PLB05-06, PLB07-08, PLB09-10, PLB11-12 and PLB13-14). In general, the convention used in this map from the NSF is to portray NSF fields, no matter how many may apply, as only going into the first applicable PLB or CAS pair. However, it is important to note that multiple pairs are possible if there are appropriate reasons to map multiple NSF fields into a given CAS or PLB segment. In other words, the six pairs in each PLB or CAS segment can potentially hold six different adjustments mapped from the NSF. If more than six adjustments need be shown, the applicable segments can be repeated.

One exception to this convention is found in the mapping in the 2-090-CAS segment in the Implementation Detail in Part 4. Here, NSF Fields 450-22 (deductible) and 450-23 (coinsurance) are shown as mapping to both 2-090-CAS03 and 06. This is done because this segment is dedicated to portraying patient responsibility adjustments (CAS01 (claim adjustment group code) = "PR" = patient responsibility). When both deductible and co-insurance are owed, they would both be shown in this segment using the first two pairs. If the deductible is met, only co-insurance is due and one pair used.

This implementation guide makes all PLB reason code elements (PLB03, etc.) compound elements. There are three pieces to this compound: Position 1 is a prefix, Positions 2-18 may hold a financial control number, and Positions 19-30 can contain a previous HIC number. The mapping of NSF Fields 700-04, 700-06 and 700-08 to PLB03 reflect the compound nature of this element. Given the previously described convention, this mapping is not repeated for every PLB pair, but should be assumed to be able to be repeated in subsequent pairs if necessary.

Qualifiers in the 835

In many instances, the information in one NSF field is relayed in two 835 elements. For example, 1-060.B-REF01 contains a qualifier telling how the following identification number in 1-060.B-REF02 is to be understood. In these situations, the NSF to 835 map below shows the qualifier in ( ) after the data containing 835 element (i.e., 1-060.B-REF02 (EV) is shown in the map below because "EV" is the qualifier in the preceding REF01).

In cases where there are two preceding qualifiers, the qualifier in the element immediately preceding the data-filled element is shown first, the qualifier for the element two places before the data-filled element is shown in the second, as in the case of NM103-05, where (1) is the qualifier in NM102 and (QC) is the qualifier in NM101. However, CAS segments, because they are so complex, again prove to be an exception. For these segments, only the qualifier which is shown in CAS01 is given in ( ). Though CAS02 provides a reason code in every instance, the multiple possible codes that could be used in just one element make fitting a particular code into the mapping scheme a somewhat pointless task.

Code Lists in the 835 - CLP Segment

In general, code lists needed to fill elements in the 835 are Do Not Use to the NSF. However, one-to-one mapping is done for claim status codes in element 2-010-CLP02. CLP02 also maps to two distinct NSF fields: 400-18 and 400-19. Handling of this dual reference is made clear in the one-to-one code map appearing at 2-010-CLP02 in the Implementation Detail in Part 4.

100-01.0	RECORD ID "100"	Do Not Use
100-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
100-03.0	RECEIVER ID	1-060.B-REF02(EV)
100-04.0	RESERVED (100-04.0)	Do Not Use
100-05.0	SUBMITTER ID	1-040-TRN03
		1-020-BPR10
100-06.0	RESERVED (100-06.0)	Do Not Use
100-07.0	SUBMITTER NAME	Do Not Use
100-08.0	FILE CREATION DATE	Translator Generated
100-09.0	VERSION CODE-NATIONAL	"002.01"
100-10.0	FILLER-NATIONAL	Do Not Use
200-01.0	RECORD ID "200"	Do Not Use
200-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
200-03.0	SOURCE OF PAYMENT	Do Not Use
200-04.0	EMC PROV ID	Do Not Use
200-05.0	BATCH NO	1-010-ST02/SE02(835)
200-06.0	PROVIDER NAME	1-080B-N102(PE)
200-07.0	PROVIDER NO	1-080B-N104(MP)
200-08.0	CHECK NO\EFT TRACE NO	1-040-TRN02(1)
200-09.0	CHECK\EFT ISSUE DATE	1-020-BPR16
200-10.0	PAYOR PROCESS DATE	1-070-DTM02/DTM05
		(405)
200-11.0	RECVR/PROV BANK ID NO	1-020-BPR13(01)
200-12.0	RECVR/PROV ACCT NO	1-020-BPR15(DA,SG)
200-13.0	SENDER/PAYOR BANK ID NO	1-020-BPR07(01)
200-14.0	SENDER/PAYOR ACCT NO	1-020-BPR09(DA)
200-15.0	TRANS HANDLING CODE	1-020-BPR01
200-16.0	PAYMENT METHOD CODE	1-020-BPR04
200-17.0	PAYMENT FORMAT CODE	1-020-BPR05
200-18.0	RECVR/PROV TYPE OF ACCT	1-020-BPR14
200-19.0	ASSIGNED/UNASSIGNED INDICATOR	2-003.A-LX01
		2 -003.B-LX01
200-20.0	NATIONAL-FILLER	Do Not Use
400-01.0	RECORD ID "400"	Do Not Use
400-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
400-03.0	PAT CONTROL NO	2-010-CLP01
400-04.0	CHECK NO/EFT TRACER NO	Do Not Use
400-05.0	CHECK/EFT ISSUE DATE	Do Not Use
400-06.0	GROUP POLICY NO	Do Not Use
400-07.0	INSURED ID NO	2-030A-NM109(HN)
400-08.0	CORRECTED INSURED ID IND	2-030A-NM109(C)
400-09.0	INSURED LAST NAME	Do Not Use

400-10.0	INSURED FIRST NAME	Do Not Use
400-11.0	INSURED MI	Do Not Use
400-12.0	EMPLOYEE ID	Do Not Use

400-13.0	PATIENT LAST NAME	2-030A-NM103(1)(QC)
400-14.0	PATIENT FIRST NAME	2-030A-NM104(1)(QC)
400-15.0	PATIENT MIDDLE INITIAL	2-030A-NM105(1)(QC)
400-16.0	PATIENT SEX	Do Not Use
400-17.0	PATIENT DATE OF BIRTH	Do Not Use
400-18.0	COMP INSURANCE FLAG	2-010-CLP02
400-19.0	CLAIM STATUS	2-010-CLP02
400-20.0	PAYOR PHONE NO	Do Not Use
400-21.0	MEDICAL RECORD NO	Do Not Use
400-22.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
400-23.0	CLAIM REMARK CODE1	2-035-MOA03
400-24.0	CLAIM REMARK CODE2	2-035-MOA04
400-25.0	CLAIM REMARK CODE3	2-035-MOA05
400-26.0	CLAIM REMARK CODE4	2-035-MOA06
400-27.0	CLAIM REMARK CODE5	2-035-MOA07
400-28.0	CORRECTED PATIENT NAME	2-030.A-NM101
400-29.0	FILLER-NATIONAL	Do Not Use
==========| |450-01.0	RECORD ID "450"	Do Not Use
450-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
450-03.0	PAT CONTROL NO	2-010-CLP01
450-04.0	LINE CONTROL NO	2-100.D-REF02
450-05.0	SERVICE LINE NO	Do Not Use
450-06.0	LINE ITEM STATUS CODE	Do Not Use
450-07.0	SERVICE FROM DATE	2-080.A-DTM02/
		DTM05 (150/472)
450-08.0	SERVICE TO DATE	2-080.B-DTM02 (151)/
		DTM05
450-09.0	PAYOR RECEIPT DATE	2-050-DTM02 (050)/
		DTM05
450-10.0	RESERVED	Do Not Use
450-11.0	PLACE OF SERVICE	2-100.A-REF02(LU)
450-12.0	TYPE OF SERVICE	Do Not Use
450-13.0	PROCEDURE CODE	2-070-SVC01*-02 (HC)
450-14.0	HCPCS MODIFIER 1	2-070-SVC01*-03
450-15.0	HCPCS MODIFIER 2	2-070-SVC01*-04
450-16.0	HCPCS MODIFIER 3	2-070-SVC01*-05
450-17.0	UNITS OF SERVICE	2-070-SVC05
450-18.0	SUBMITTED LINE CHARGE	2-070-SVC02
450-19.0	DISALLOWED COST CONTAIN	Do Not Use
450-20.0	DISALLOWED/NONCOVERED	Do Not Use
450-21.0	ALLOWED/CONTRACT AMOUNT	2-110.A-AMT02
450-22.0	DEDUCTIBLE AMOUNT	2-090-CAS03 (PR1)
450-23.0	COINSURANCE AMOUNT	2-090-CAS03 (PR2)
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450-24.0	INTEREST AMOUNT	Do Not Use
		(See record 500)
450-25.0	GRAMM-RUDMAN REDUCTION	Do Not Use
		(See record 500)

450-26.0	AMT PAID BY OTHER PAYOR	2-090-CAS03 (OA71)
450-27.0	PROV ADJUSTMENT	Do Not Use
450-28.0	CALC PAY TO PROV	2-070-SVC03
450-29.0	CALC PAY TO PAYEE	Do Not Use
450-30.0	PREV PAY TO PROV	Do Not Use
450-31.0	PREV PAY TO PAYEE	Do Not Use
450-32.0	ACTUAL PAY TO PROV	Do Not Use
450-33.0	ACTUAL PAY TO PAYEE	2-090-CAS03 (OA100)
450-34.0	PAYMENT LEVEL BY PERCENT	Do Not Use
450-35.0	PPO/HMO IND	Do Not Use
450-36.0	FACILITY/SUPPLIER ID	2-100.C-REF02(1J)
450-37.0	PERFORMING PROV ID	2-100.B-REF02(1C)
450-38.0	GROUP AND REASON CODE 1	2-090-CAS01/CAS02 (NOTE: Group is always CAS01)
450-39.0	GROUP AND REASON CODE 2	2-090-CAS01/CAS05
450-40.0	GROUP AND REASON CODE 3	2-090-CAS01/CAS08
450-41.0	GROUP AND REASON CODE 4	2-090-CAS01/CAS11
450-42.0	GROUP AND REASON CODE 5	2-090-CAS01/CAS14
450-43.0	GROUP AND REASON CODE 6	2-090-CAS01/CAS17
450-44.0	GROUP AND REASON CODE 7	2-090-CAS01/CAS02 (2nd loop)
450-45.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
450-46.0	MODIFIER 4	Do Not Use
450-47.0	FILLER-NATIONAL	Do Not Use
451-01.0	RECORD ID "451"	Do Not Use
451-02.0	PAYOR ID	1-020-BPR10 1-080.A-N104 1-040-TRN03
451-03.0	PAT CONTROL NO	2-010-CLP01
451-04.0	LINE CONTROL NO	Do Not Use
451-05.0	SERVICE LINE NO	Do Not Use
451-06.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
451-07.0	LATE FILING REDUCTION	2-110.B-AMT02
451-08.0	AMOUNT PATIENT OWES	Do Not Use
451-09.0	ORIGINAL PROCEDURE CODE	2-070-SVC06*-02(HC)
451-10.0	DOLLAR AMOUNT 1	2-090-CAS03
451-11.0	DOLLAR AMOUNT 2	2-090-CAS06
451-12.0	DOLLAR AMOUNT 3	2-090-CAS09
451-13.0	DOLLAR AMOUNT 4	2-090-CAS12
451-14.0	DOLLAR AMOUNT 5	2-090-CAS15
451-15.0	NATIONAL DRUG CODE	Do Not Use
451-16.0	LINE REMARK CODE 1	2-130-LQ02
451-17.0	LINE REMARK CODE 2	2-130-LQ02
451-18.0	LINE REMARK CODE 3	2-130-LQ02
451-19.0	LINE REMARK CODE 4	2-130-LQ02
451-20.0	LINE REMARK CODE 5	2-130-LQ02

451-21.0	LINE REMARK CODE DATE	2-130-LQ02
451-22.0	DOLLAR AMOUNT 6	2-090-CAS18
451-23.0	DOLLAR AMOUNT 7	2-090-CAS03 (2nd loop)
451-24.0	AMOUNT PATIENT PAID	Do Not Use
451-25.0	ORIGINAL UNITS OF SERVICE	2-070-SVC07
451-26.0	FILLER-NATIONAL	Do Not Use

500-01.0	RECORD ID "500"	Do Not Use	
500-02.0	PAYOR ID	1-020-BPR10 1-080.A-N104 1-040-TRN03	
500-03.0	PAT CONTROL NO	2-010-CLP01	
500-04.0	CT LINE ITEMS	Do Not Use	
500-05.0	CT SUBMITTED CHARGES	2-010-CLP03	
500-06.0	CT DISALLOW-COST CONT	Do Not Use	
500-07.0	CT DISALLOW/NONCOVER	Do Not Use	
500-08.0	CT ALLOWED	Do Not Use	
500-09.0	CT DEDUCTIBLE	Do Not Use	
500-10.0	CT COINSURANCE	Do Not Use	
500-11.0	CT INTEREST PAID	2-062-AMT02	
500-12.0	CT GRAMM-RUDMAN RED	2-020-CAS03 (CO43)	
500-13.0	CT AMT PAID BY OTHER PAYOR	Do Not Use	
500-14.0	CT PROV ADJUSTMENT	Do Not Use	
500-15.0	CT CALC PAY TO PROV	2-010-CLP04	
500-16.0	CT CALC PAY TO PAYEE	Do Not Use	
500-17.0	CT PREV PAY TO PROV	2-020-CAS03 (0AB13)	
500-18.0	CT PREV PAY TO PAYEE	2-020-CAS03	
500-19.0	CT ACTUAL PAY TO PROV	Do Not Use	
500-20.0	CT ACTUAL PAY TO PAYEE	Do Not Use	
500-21.0	PAYOR CLAIM CONTROL NO	2-010-CLP07	
500-22.0	CT LATE FILING REDUCTION	Do Not Use	
500-23.0	CT AMOUNT PATIENT OWES	2-010-CLP05	
500-24.0	CLAIM FILING INDICATOR	Do Not Use	
500-25.0	CARRIER/SUPPLEMENTAL INSURER NAME1	2-030.B-NM103	
500-26.0	IDENTIFICATION NUMBER1	2-030.B-NM109	
500-27.0	CARRIER/SUPPLEMENTAL INSURER NAME2	2-030.C-NM103	
500-28.0	IDENTIFICATION NUMBER2	2-030.C-NM109	
500-29.0	CT AMOUNT PATIENT PAID	2-062-AMT02	
500-30.0	CLAIM ADJUSTMENT REASON CODE1	2-020-CAS02	
500-31.0	CLAIM ADJUSTMENT REASON CODE2	2-020-CAS02	
500-32.0	CLAIM ADJUSTMENT REASON CODE3	2-020-CAS02	
500-33.0	CLAIM DOLLAR AMOUNT1	2-020-CAS03	
500-34.0	CLAIM DOLLAR AMOUNT2	2-020-CAS03	
500-35.0	CLAIM DOLLAR AMOUNT3	2-020-CAS03	
500-36.0	FILLER-NATIONAL	Do Not Use	
700-01.0	RECORD ID "700"	Do Not Use	

700-02.0	PAYOR ID	1-020-BPR10 1-080.A-N104 1-040-TRN03	
700-03.0	SEQUENCE NO	Do Not Use	
700-04.0	HIC NO	3-010-PLB03 (Positions 20 - 30)	
700-05.0	PATIENT ACCT NO	Do Not Use	

700-06.0	ADJUSTMENT REASON	3-010-PLB03	
		(Positions 1 - 2)	
700-07.0	ADJUSTMENT AMOUNT	3-010-PLB04	
700-08.0	FINANCIAL CONTROL NO	3-010-PLB03	
		(Positions 3 - 19)	
700-09.0	FILLER-NATIONAL	Do Not Use	
800-01.0	RECORD ID "800"	Do Not Use	
800-02.0	PAYOR ID	1-020-BPR10	
		1-080.A-N104	
		1-040-TRN03	
800-03.0	SOURCE OF PAYMENT	Do Not Use	
800-04.0	EMC PROV ID	Do Not Use	
800-05.0	BATCH NO	1-010-ST02/SE02(835)	
800-06.0	BT CLAIM RECORDS	Do Not Use	
800-07.0	BT SERV DATA REC	Do Not Use	
800-08.0	BT SUBMITTED CHARGES	Do Not Use	
800-09.0	BT DISALLOW-COST CONT	Do Not Use	
800-10.0	BT DISALLOW/NONCOVER	Do Not Use	
800-11.0	BT ALLOWED	Do Not Use	
800-12.0	BT DEDUCTIBLE	Do Not Use	
800-13.0	BT COINSURANCE	Do Not Use	
800-14.0	BT INTEREST PAID	Do Not Use	
800-15.0	BT GRAMM-RUDMAN RED	Do Not Use	
800-16.0	BT AMT PAID OTHER PAYOR	Do Not Use	
800-17.0	BT PROV ADJUSTMENT	Do Not Use	
800-18.0	BT CALC PAY TO PROV	Do Not Use	
800-19.0	BT CALC PAY TO PAYEE	Do Not Use	
800-20.0	BT PREV PAY TO PROV	Do Not Use	
800-21.0	BT PREV PAY TO PAYEE	Do Not Use	
800-22.0	BT ACTUAL PAY TO PROV	1-020-BPR02	
800-23.0	BT ACTUAL PAY TO PAYEE	Do Not Use	
800-24.0	BT LATE FILING REDUCTION	Do Not Use	
800-25.0	BT AMOUNT PATIENT OWES	Do Not Use	
800-26.0	FILLER	Do Not Use	
800-27.0	BT TOTAL PROV ADJUST RECS	Do Not Use	
800-28.0	BT TOTAL PROV ADJUST AMT	Do Not Use	
800-29.0	BT AMOUNT PATIENT PAID	Do Not Use	
800-30.0	FILLER-NATIONAL	Do Not Use	
900-01.0	RECORD ID "900"	Do Not Use	
900-02.0	PAYOR ID	1-020-BPR10	
		1-080.A-N104	
		1-040-TRN03	

900-03.0	RECEIVER ID	1-060.B-REF02(EV)	
900-04.0	RESERVED (900-04.0)	Do Not Use	
900-05.0	SUBMITTER ID	1-040-TRN03,	
		1-020-BPR-10	
900-06.0	RESERVED (900-06.0)	Do Not Use	
900-07.0	FT BATCHES	Do Not Use	
900-08.0	FT PATIENT RECORDS	Do Not Use	

900-09.0	FT SUBMITTED CHARGES	Do Not Use
900-10.0	FT DISALLOW-COST CONT	Do Not Use
900-11.0	FT DISALLOW/NONCOVER	Do Not Use
900-12.0	FT ALLOWED	Do Not Use
900-13.0	FT DEDUCTIBLE	Do Not Use
900-14.0	FT COINSURANCE	Do Not Use
900-15.0	FT INTEREST PAID	Do Not Use
900-16.0	FT GRAMM-RUDMAN RED	Do Not Use
900-17.0	FT AMT PAID OTHER PAYOR	Do Not Use
900-18.0	FT PROV ADJUSTMENT	Do Not Use
900-19.0	FT CALC PAY TO PROV	Do Not Use
900-20.0	FT CALC PAY TO PAYEE	Do Not Use
900-21.0	FT PREV PAY PROV	Do Not Use
900-22.0	FT PREV PAY PAYEE	Do Not Use
900-23.0	FT ACTUAL PAY TO PROV	Do Not Use
900-24.0	FT ACTUAL PAY TO PAYEE	Do Not Use
900-25.0	FT LATE FILING REDUCTION	Do Not Use
900-26.0	FT AMOUNT PATIENT OWES	Do Not Use
900-27.0	FT AMOUNT PATIENT PAID	Do Not Use
900-28.0	FILLER	Do Not Use
900-29.0	FT TOTAL PROV ADJUST RECS	Do Not Use
900-30.0	FT TOTAL PROV ADJUST AMT	Do Not Use
900-31.0	FILLER-NATIONAL	Do Not Use

Some Specific CAS Mappings

The left column in this chart shows the NSF position. The type of adjustment is specified in the center column. The right column shows, reading left to right, the 835 position (2-090, etc.), the functional group code in the CAS01 element (i.e., PR), and the reason code [see Appendix C] in the CAS02 element that would be used to represent the adjustment listed in the center column.

450-22.0	Deductible	2-090 (PR)(1)
450-23.0	Coinsurance	2-090 (PR)(2)
450-33.0	Payment to beneficiary	2-090 (OA)(100)
500-12.0	Gramm-Rudman reduction	2-020 (CO)(43)

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Standard Claim Adjustment Reason Codes 6/97

Any reference to procedures or services in the Claim Adjustment Reason Codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs). An "*" after a code value denotes that the code value is inactive as of release of version 3040 of the 835. An "^" after a code value denotes that the code value is inactive as of release of version 3050 of the 835. Codes with either of these symbols may not be used in post 3040 and/or 3050 versions of the 835 or versions of the NSF 2.0 or later.

This list supersedes earlier CAS reason code lists. The indicated wording may not be modified without approval of the X12 Claim Reason and Status Code Task Group. These codes were developed for use by all U.S. health payers. As result, they are generic, and there are a number of codes that do not apply to Medicare. These are the only CAS reason codes approved for use in Medicare 835, National Standard Format (NSF) and standard Medicare paper remittance advice transactions.

These reason codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment. CAS reason codes may be used at the service or claim level, as appropriate. At least one CAS reason code must be used per claim. Code 93, claim paid in full, must be used at the claim level when there have not been any adjustments. Multiple CAS reason codes may be entered for each service or claim as warranted.

Early in the history of CAS reason codes, some codes, such as 69-83 were implemented for informational rather than adjustment purposes. However, these codes and their amounts interfered with balancing of the remittance data. Approval of new codes is now limited to those that involve an adjustment from the amount billed.

There are basic criteria that the X12 Claims Adjustment and Status Task Group considers when evaluating requests for new codes:

1. Can the information be conveyed by the use or modification of an existing CAS reason code?

2. Is the information available elsewhere in the 835?

3. Will the addition of the new CAS reason code make any significant difference in the action taken by the provider who receives the message?

Requests for CAS reason code changes must satisfy these questions prior to approval.

CAS Code Value	Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-Payment Amount
4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.

CAS Code Value	Description
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's sex.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's sex.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Claim/service denied because the submitted authorization number is missing or invalid.
16	Claim/service lacks information which is needed for adjudication.
17	Claim/service denied because requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury and thus the liability of the Worker's Compensation carrier.
20	Claim denied because this injury is covered by the liability carrier.
21	Claim denied because this injury is the liability of the no-fault carrier.
22	Claim denied because this care may be covered by another payer per coordination of benefits.
23	Claim denied/reduced because charges have been paid by another payer as part of coordination of benefits.
24	Payment for charges denied. Charges are covered under a capitation agreement.
25	Charges denied. Your stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time service was provided.
29	The time limit for filing has expired.
30	Benefits are not available for these services until the patient has met the required waiting or residency period.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
36 *	Balance does not exceed co-payment amount.
37 *	Balance does not exceed deductible.
38	Services are not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/precertification was requested.
40	Charges do not meet qualifications for emergency/urgent care out-of-area.
41 *	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis (es) are not covered.
48	This (these) procedure(s) is (are) not covered.

CAS Code Value	Description
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a “medical necessity” by the payer.
51	These are non-covered services because this is a pre-existing condition.
52	The referring/prescribing provider is not eligible to refer/prescribe/order the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed “proven to be effective” by the payer.
57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are reduced based on multiple surgery rules or concurrent anesthesia rules.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges reduced as penalty for failure to obtain second surgical opinion.
62	Penalty taken for absence of or exceeded pre-certification authorization.
63 *	Correction to a prior claim.
64 *	Denial reversed per Medical Review.
65 *	Procedure code was incorrect. This payment reflects the correct code.
66	Blood deductible.
67 *	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68 *	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier amount.
71	Primary payer amount.
72 *	Coinsurance day. (Handled in QTY, QTY01=CD)
73 ^	Administrative days.
74	Indirect medical education adjustment.
75	Direct medical education adjustment.
76	Disproportionate share adjustment.
77 *	Covered days. (Handled in QTY, QTY01=CA)
78	Non-covered days/Room charge adjustment.
79 ^	Cost report days. (Handled in MIA15)
80 ^	Outlier days. (Handled in QTY, QTY01=OU)
81 *	Discharges.
82 *	PIP days.
83 *	Total visits.
84 ^	Capital adjustment. (Handled in MIA)
85	Interest amount.
86	Statutory adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.

CAS Code Value	Description
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92 *	Claim paid in full.
93	No claim level adjustments.
94	Processed in excess of charges.
95	Benefits reduced. Plan procedures not followed.
96	Non-covered charges.
97	Payment is included in the allowance for the basic service/procedure.
98 *	The hospital must file the Medicare claim for this inpatient non-physician service.
99 *	Medicare Secondary Payer adjustment amount.
100	Payment made to patient/insured/responsible party.
101	Predetermination, anticipated payment upon completion of services.
102	Major medical adjustment.
103	Provider promotional discount (i.e. Senior citizen discount)
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Claim/service denied/reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Claim/service denied/reduced as not furnished directly to the patient and/or not documented.
113	Claim denied because service/procedure was provided outside of the United States or as result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Claim/service denied/reduced as procedure postponed or canceled.
116	Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period has been reached.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payor refund amount due to overpayment.
124	Payor refund amount--not our patient.
125	Claim/service denied/reduced due to a submission/billing error(s).
126	Deductible--major medical.
127	Coinsurance--major medical.
128	Newborn’s services are covered in the mother’s allowance.
129	Claim denied--prior processing information appears incorrect.
130	Paper claim submission fee. (Not Medicare)

CAS Code Value	Description
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare claim PPS day capital outlier amount.
A5	Medicare claim PPS cost capital outlier amount.
A6	Prior hospitalization or 30-day transfer requirement not met.
A7	Presumptive payment adjustment.
A8	Claim denied. Ungroupable DRG.
B1	Non-covered visits.
B2 *	Covered visits.
B3 *	Covered charges.
B4	Late filing penalty.
B5	Claim/service denied/reduced because coverage guidelines were not met or were exceeded.
B6	This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services are not covered because the patient is enrolled in a hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patient's medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Claim/service denied because only one visit or consultation per physician per day is covered.
B15	Claim/service denied/reduced because this procedure/service is not paid separately.
B16	Claim/service denied/reduced because "New Patient" qualifications were not met.
B17	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	Claim/service denied/reduced because of the finding of a review organization.
B20	Charges denied/reduced because procedure/service was partially or fully furnished by another provider.
B21 *	The charges were reduced because the service/care was partially furnished by another physician.
B22	This claim/service is denied based on the diagnosis.
B23	Claim/service denied because this provider has failed an aspect of a proficiency testing program.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D2	Claim lacks the name, strength or dosage of the drug furnished.

CAS Code Value	Description
D3	Claim,/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that "X-ray is available for review."
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts, or the type of intraocular lens used.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that the plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
	For demonstration program use only:
D97	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
D98	Part B coinsurance. (Part B Center of Excellence Demonstration)
D99	Adjustment to the pre-demonstration rate.

MEDICARE LINE LEVEL REMARK CODES

Remark codes must be used to relay service-specific Medicare informational messages that cannot be expressed with a reason code. Medicare remark codes are maintained by HCFA. As with the CAS reason codes, Medicare contractors are also prohibited from use of local remark codes.

Remark codes and messages must be used whenever they apply. Although contractors may use their discretion to determine when certain remark codes apply, they do not have discretion as to whether to use an applicable remark code in a remittance notice. A limitation of liability message (M25-M27) must be used where applicable. An unlimited number of Medicare line level remark codes may be entered as warranted in an X12 835 RA; there is a limit of 5 line level remark code entries in a NSF RA and on a standard paper remittance notice.

Line Level Remark Codes

Code Value	Description
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M16	Please see the letter or bulletin of (date) for further information. [Note: Contractor must enter the date of the letter/bulletin.]
M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.

M18 Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.

M19 Oxygen certification/recertification (HCFA-484) is incomplete or is required.

M20 HCPCS needed.

M21 Claim for services/items provided in a home must indicate the place of residence.

M22 Claim lacks the number of miles traveled.

M23 Invoice needed for the cost of the material or contrast agent.

M24 Claim must indicate the number of doses per vial.

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- o If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or
- o If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

M27 The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28 This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29 Claim lacks the operative report.
M30 Claim lacks the pathology report.
M31 Claim lacks the radiology report.
M32 This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33 Claim lacks the UPIN of the ordering/referring or performing physician, or the UPIN is invalid.
M34 Claim lacks the CLIA certification number.
M35 Claim lacks pre-operative photos or visual field results.
M36 This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37 Service not covered when the beneficiary is under age 35.
M38 The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39 The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40 Claim must be assigned and must be filed by the practitioner's employer.
M41 We do not pay for this as the patient has no legal obligation to pay for this.
M42 The medical necessity form must be personally signed by the attending physician.
M43 Payment for this service previously issued to you or another provider by another Medicare carrier/intermediary.
M44 Incomplete/invalid condition code.
M45 Incomplete/invalid occurrence codes and dates.
M46 Incomplete/invalid occurrence span code and dates.
M47 Incomplete/invalid internal or document control number.

M48	Medicare payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49	Incomplete/invalid value code(s) and/or amount(s).
M50	Incomplete/invalid revenue code(s).
M51	Incomplete/invalid, procedure code(s) and/or rates, including “not otherwise classified” or “unlisted” procedure codes. Refer to the HCFA Common Procedure Coding System. (Add to message for carriers only: If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.)
M52	Incomplete/invalid “from” date(s) of service.
M53	Did not complete or enter the appropriate number (one or more) of days or units(s) of service.
M54	Did not complete or enter the correct total charges for services rendered.
M55	Medicare does not pay for self-administered anti-emetic drugs that are not administered with a Medicare-covered oral anti-cancer drug.
M56	Incomplete/invalid payer identification.
M57	Incomplete/invalid provider number.
M58	Please resubmit the claim with the missing/correct information so that it may be processed.
M59	Incomplete/invalid “to” date(s) of service.
M60	Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Incomplete/invalid treatment authorization code.
M63	Medicare does not pay for more than one of these on the same day.
M64	Incomplete/invalid other diagnosis code.
M65	Only one technical component can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each technical component code.
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Incomplete/invalid other procedure code(s) and/or date(s).
M68	Incomplete/invalid attending or referring physician identification.
M69	Paid at the regular rate as you did not submit documentation to justify modifier 22.
M70	NDC code submitted for this service was translated to a HCPCS code for Medicare processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.
M72	Did not enter full 8-digit date (MM/DD/CCYY).
M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.
M74	This service does not qualify for a HPSA bonus payment.
M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76	Incomplete/invalid patient's diagnosis(es) and condition(s).
M77	Incomplete/invalid place of service(s).
M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79	Did not complete or enter the appropriate charge for each listed service.
M80	We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.

M81	Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82	Service is not covered when beneficiary is under age 50.
M83	Service is not covered unless the beneficiary is classified as at high risk.
M84	Old and New HCPCS cannot be billed for the same date of service.
M85	Subjected to review of physician evaluation and management services.
M86	Service denied because payment already made for similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review..
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home Health Medical Review Initiative.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Incomplete/invalid/missing Universal Product Number.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.
M103	Information supplied supports a break in therapy. However, the medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the Medicare fee schedule for this item or service.
M105	Information supplied does not support a break in therapy. The medical information we have for this beneficiary does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the Medicare fee schedule for this item or service.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108	and higher Reser ved for future use.

MEDICARE CLAIM LEVEL REMARKS CODES

A maximum of 5 of these claim level Medicare Inpatient Adjudication (MIA) and 5 of these claim level Medicare Outpatient Adjudication (MOA) remarks codes may be used per claim. See the Medicare 835 Implementation Guides. Insert these codes in the space for semantics 5 or 20-23 of the MIA segment or semantics 3-7 of the MOA segment as applicable. These semantics were previously reserved for local message codes. Previously established MIA/MOA semantic codes [MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09] are not impacted by this instruction and must continue to be used as indicated in the Medicare Part A 835 Implementation Guide. MIA01, 03-04, 06-19 and 24, and MOA01-02 and 08-09 as listed in the Part A 835 Implementation Guide do not apply to the NSF, but individual Medicare MIA/MOA remarks codes listed in this document must also be used in the NSF and the standard paper remittance notice. See NSF and standard paper remittance notice specifications for use of Medicare MIA/MOA remarks codes in NSF and paper RAs.

Medicare MIA/MOA remarks codes are used to convey appeal information and other claim-specific information that does not involve a financial adjustment. As with the 835/NSF reason and Medicare line level remarks codes, Medicare contractors are also prohibited from use of local MIA/MOA codes.

An appropriate appeal, limitation of liability or other message must be used whenever applicable. Although contractors have discretion to determine when certain remarks codes and messages apply, they do not have discretion as to whether to use applicable codes and messages.

Code Value	Description
MA01	(Initial Part B determination, carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. (Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.) (NOTE: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)
MA02	(Initial Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA03 (Hearing)--If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance) , you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05 Incorrect admission date, patient status or type of bill entry on claim.
(NOTE: See MA30, MA40 and MA43 also.)

MA06 Incorrect beginning and/or ending date(s) on claim.

MA07 The claim information has also been forwarded to Medicaid for review.

MA08 You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

MA09 Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10 The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.

MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13 You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17 We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

MA19 Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.

MA20 SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA2 SSA records indicate mismatch with name and sex.

MA22 Payment of less than $1.00 suppressed.

MA23 Demand bill approved as result of medical review.
MA24 Christian Science Sanitorium/ SNF bill in the same benefit period.
MA25 A patient may not elect to change a hospice provider more than once in a benefit period.
MA26 Our records indicate that you were previously informed of this rule.
MA27 Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.
MA28 Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA29 Incomplete/invalid provider name, city, state, and zip code.
MA30 Incomplete/invalid type of bill.
MA31 Incomplete/invalid beginning and ending dates of the period billed.
MA32 Incomplete/invalid number of covered days during the billing period.
MA33 Incomplete/invalid number of noncovered days during the billing period.
MA34 Incomplete/invalid number of coinsurance days during the billing period.
MA35 Incomplete/invalid number of lifetime reserve days.
MA36 Incomplete/invalid patient's name.
MA37 Incomplete/invalid patient's address. (Note: When used, a Medicare contractor must verify that an address, with city, State, and zip code, and a phone number are present.)
MA38 Incomplete/invalid patient's birthdate.
MA39 Incomplete/invalid patient's sex.
MA40 Incomplete/invalid admission date.
MA41 Incomplete/invalid type of admission.
MA42 Incomplete/invalid source of admission.
MA43 Incomplete/invalid patient status.
MA44 No appeal rights on this claim. Every adjudicative decision based on Medicare law.
MA45 As previously advised, a portion or all of your payment is being held in a special account.
MA46 The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
MA47 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment
MA48 Incomplete/invalid name and/or address of responsible party or primary payer .
MA49 Incomplete/invalid six-digit Medicare provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52 Did not enter full 8-digit date (MM/DD/CCYY).
MA53 Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54 Physician certification or election consent for hospice care not received timely.
MA55 Not covered as patient received voluntary medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57 Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58 Incomplete release of information indicator.

MA59 The beneficiary overpaid you for these services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60 Incomplete/invalid patient's relationship to insured.
MA61 Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62 Telephone review decision
MA63 Incomplete/invalid principal diagnosis code.
MA64 Our records indicate that Medicare should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65 Incomplete/invalid admitting diagnosis.
MA66 Incomplete/invalid principal procedure code and/or date.
MA67 Correction to a prior claim.
MA68 We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PAYERID of the insurer to assure correct and timely routing of the claim.
MA69 Incomplete/invalid remarks.
MA70 Incomplete provider representative signature.
MA71 Incomplete/invalid provider representative signature date.
MA72 The beneficiary overpaid you for these assigned services. You must issue the beneficiary a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the beneficiary on this notice.
MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.
MA77 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the beneficiary’s payment less the total of Medicare and other payer payments and the amount shown as patient responsibility on this notice.
MA78 The beneficiary overpaid you. You must issue the beneficiary a refund within 30 days for the difference between the Medicare allowed amount total and the amount paid by the beneficiary.
MA79 Billed in excess of interim rate.
MA80 Informational notice. No payment issued for this claim with this notice. Medicare payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.
MA82 Did not complete or enter the correct physician/supplier's Medicare billing number/NPI and/ or billing name, address, city, state, zip code, and phone number.
MA83 Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
MA84 Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
MA85 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the primary payer’s plan or program name. (Substitute “PAYERID” for “their plan or program name” when effective.)
MA86 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group or policy number of the insured.

MA87 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.

MA88 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA90 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91 This determination is the result of the appeal you filed.

MA92 Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information. (NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93 Non-PIP claim.

MA94 Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95 A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

MA96 Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

MA97 Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.

MA98 Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.

MA99 Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100 Did not complete or enter accurately the date of current illness, injury or pregnancy.

MA101 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102 Did not complete or enter accurately the referring/ordering/supervising physician's name and/or UPIN. (Substitute "NPI" for "UPIN" when effective.)

MA103 Hemophilia Add On

MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)

MA105 Reserved for future use.
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MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.

MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 Our records indicate that the performing physician/supplier is a member of a group practice; however, you did not complete or enter accurately their carrier assigned PIN. (Substitute "NPI" for "PIN" when effective.)

MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.

MA114 Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute "NPI" for "PIN" when effective.)

MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute “NPI” for “PIN” when effective.)

MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.

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MA120 Did not complete or enter accurately the CLIA number.

MA121 Did not complete or enter accurately the date the X-Ray was performed.

MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.

MA123 Your center was not selected to participate in this study, therefore, we cannot pay for these services.

MA124-127 Reserved for future use

MA128 Did not complete or enter accurately the six digit FDA approved, identification number.

MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Please contact _____to correct or obtain CLIA certification. (Claim processor must insert the name and phone number of the State Agency to be contacted.)

MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

MA131 and higher Reserved for future use.

Appendix D

You may obtain the paper publication titled "An Introduction to Electronic Data Interchange" from:

Publications Department
Data Interchange Standards Association, Inc.
1800 Diagonal Road, Suite 355
Alexandria, VA 22314-2852
(703) 548-7005

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